Luke's Journal

of Christian Medicine & Dentistry
Vol. 26 No. 2 June 2021
ISSN 2209-9441

Christian Medical and Dental Fellowship of Australia

When God doesn't Heal

CMDFA Position Statement on Immunisation: Personal Safety and Public Health

Encounters with Death: Reflections of a Medical Student

Reflections of a Grieving Mother

Dying Young ...

Dying & Palliative Care

Managing the Dying: The Gospel, Spirituality or Both?

The Journey Home

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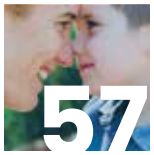

Luke's Journal

Themes for Next Editions:

Children of God
copy due 30 Aug 2021

Rest
copy due 15 Jan 2022

Dr Iain Poi
Dr Iain Poi is a general dentist who works in private practice, aged care and prisons around Victoria.

EDITORIAL

Dying and Palliative Care

The Journey Home

Cover Theme Photo: Eleasa Sieh

We are generally optimistic about our work in healthcare: happy that we can usually relieve pain or alleviate suffering. Yet, there comes a point when traditional remedies cease to work, when the curse of death starts to take over the gift of life, and our stewardship of it begins to visibly and miserably fail. What do we do then?

In this issue of *Luke's Journal*, Christian healthcare practitioners from all around Australia have been sharing their experiences and ways to deal with this issue.

Palliative care can be immensely painful. Sustaining a deteriorating and withering patient (whilst watching them grow weaker and weaker) may seem like trying to rescue a drowning person who is chained to a sinking Titanic – heavy, somber, dire and alarming. Yet, where there is life, we are called to sustain and salvage it, little though there may be.

If they are not Christian, we can only try to shed a little Christ-like light into our patient's lives, humbly until the very end. If we have a long-standing relationship and consent, there might even possibly be an opportunity to share with them the eternal and perfect cure to be found in Jesus Christ. If Christian, we can share in their joy and hope as we fare them well on their journey home back to the Father and King.

> ***"Where there is life, we are called to sustain and salvage it, little though there may be."***

Listen, I tell you a mystery: We will not all sleep, but we will all be changed—in an instant, in the twinkling of an eye, at the last trumpet. For the trumpet will sound, the dead will be raised imperishable, and we will be changed. For the perishable must be clothed with the imperishable, and the mortal with immortality.

When the perishable has been clothed with the imperishable and the mortal with immortality, then the saying that is written will come to pass: "Death has been swallowed up in victory."

"Where, O Death, is your victory? Where, O Death, is your sting?"
1 Corinthians 15:51-55

On behalf of *Luke's Journal* Editorial team and its contributors, we present to you Dying and Palliative Care - The Journey Home and hope you are edified by it.

The Ethics Management Team (EMT) are hoping to gradually work on ethics-related resources for our membership.

The document on Moral Injury was the first and now these two covenants.

The members of the Ethics Management Team:
- Dr Andrew Sloane (Chair)
- Dr Megan Best
- Ms Gabrielle Macauley (NCF Rep)
- Dr Joseph Thomas
- Dr Lachlan Dunjey
- Dr Rohit Joshi
- Ms Anna Walsh (Legal Rep)
- Mr Ian Gowlett (Additional NCF Rep)
- Dr Kuruvilla George (CMDFA Board Rep)

Christian Dentist's Covenant

With gratitude to God, faith in Christ Jesus, and dependence on the Holy Spirit, I profess my intent to practice dentistry for the glory of God.

With humility, I will seek to keep up-to-date and increase my knowledge and skills. I will respect those who teach me and who broaden my knowledge. In turn, I will freely impart my knowledge and wisdom to others.

With God's help, I will love those who come to me for healing and comfort. I will honour and care for each patient as a person made in the image of God, striving to put aside selfish interests.

With God's guidance, I will endeavour to be a good steward of my skills and of society's resources. I will convey God's love in my relationships with family, friends, community, my patients and my colleagues. I will aspire to reflect God's loving kindness in caring for those in need.

I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient.

With God's grace, I will live according to this covenant.

Christian Doctor's Covenant

With gratitude to God, faith in Christ Jesus, and dependence on the Holy Spirit, I profess my intent to practice medicine for the glory of God.

With humility, I will seek to keep up-to-date and increase my knowledge and skills. I will respect those who teach me and who broaden my knowledge. In turn, I will freely impart my knowledge and wisdom to others.

With God's help, I will love those who come to me for healing and comfort. I will honour and care for each patient as a person made in the image of God, putting aside selfish interests, remaining pure and honouring God in all my behaviours.

With God's guidance, I will endeavour to be a good steward of my skills and of society's resources. I will convey God's love in my relationships with family, friends, community, my patients and my colleagues. I will aspire to reflect God's loving kindness in caring for the lonely, the poor, the vulnerable, the marginalised, the suffering and the dying.

I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient.

I will value human life as created in the image of God. I will care for all my patients, rejecting those interventions that either intentionally destroy or actively end human life.

With God's guidance and wisdom, I will endeavour to abide by the law of the land but when it is in conflict with God's commandments, I will heal on request even if the law of the land forbids it and refuse treatments and procedures even when the law compels it.

With God's grace, I will live according to this covenant.

Prof John Attia
John studied physiology, neurobiology, epidemiology and medicine in Canada and moved to Australia over 20 years ago. He is now Laureate Professor of Medicine and Clinical Epidemiology and Assistant Dean Research in the Faculty of Health at the University of Newcastle. He is married to Melissa and they have four children, attending the Grainery Church in Newcastle, where he occasionally preaches. email: john.attia@newcastle.edu.au

Photo: Sixteen Miles Out at Unsplash

Learning about Death from Jesus

Why we Mourn

"It is ironic that a community that has a story about death at the centre of its Scriptures and its practices of baptism and Eucharist, should fall so often silent about death."
(Allen Verhey,
The Christian Art of Dying[1]*)*

As a general physician who has recently retrained in palliative care, I am constantly surprised by how unprepared the vast majority of people are when facing the prospect of death.

It was Italian philosopher, Umberto Eco, who said: "It is necessary to meditate early, and often, on the art of dying to succeed later in doing it properly just once."[2] The apostle Paul, who went through many trials and risked death many times (see 2 Cor 11:23-27), reflects that he *"eagerly expects and hopes that… now, as always, Christ will be exalted in his body, whether by life or by death."* (Phil 1:20). Being a believer, therefore, means that we can worship God, not only in the way we live, but also by the way we die.

To understand this idea fully we must first understand death fully. The Greeks summarised the three major approaches to understanding death through history:

- **Death as a release from the body**: Socrates, Plato and Aristotle all viewed the body as corruptible and death was a release from the physical body and a triumph of the spiritual self.
- **Death is natural:** the Stoics saw death as natural and hence anything in accordance with nature was to be accepted cheerfully.
- **Death is final:** Epicurus saw death as the end of the body and soul and the return of atoms to where they began with nothing further.

In contrast, the Bible tells us that God the Trinity has created us as a trinity of body, soul, and spirit to enjoy life with Him:

> ***"We can worship God, not only in the way we live, but also by the way we die."***

Now may the God of peace himself sanctify you completely, and may your whole spirit and soul and body be kept blameless at the coming of our Lord Jesus Christ. (Thes 5:23)

- **Body:** from the Greek *soma*, meaning our physical body. We enjoy good food, good coffee, a cool swim on a hot day.
- **Soul:** from the Greek *psyche*, meaning our heart and mind, our emotional and intellectual selves. We are in community with others and can engage in work that is intellectually stimulating and creative.
- **Spirit:** from the Greek *pneuma* (wind), meaning the breath of God in us, our spirit in conjunction with the Holy Spirit. We can worship, pray and praise our Creator.

In Old Testament Jewish thought, all of these good things were brought to an end by death, including our relationship with God: *"The grave cannot praise you… those who go down to Sheol cannot hope for your faithfulness."* (Is 38:18). Death brings the curtain down on all the good that God intended for his

creation at every level. It is this finality that often fills our patients with fear and apprehension – what the palliative care field calls 'psychospiritual' or 'existential' distress. This finality deserves to be recognised and mourned.

This recognition of finality is exactly what we see with Jesus' interaction with Lazarus. When Jesus hears about Lazarus, he says: "*Our friend Lazarus has fallen asleep: but I am going to wake him up.*" (Jn 11:11) He is evidently planning from the start to raise Lazarus from the dead, yet when he arrives in Bethany, he does not enter the village triumphantly as if to say, "Wait till you see what I'm going to do!" Instead he takes the time to weep and mourn (Jn 11:35). It is fitting and proper to mourn and grieve those we lose to the finality of death.

This finality is why death is referred to as 'the enemy' throughout Scripture: "*He must reign until he has put all his enemies under his feet. The last enemy to be destroyed is death.*" (1 Cor 15:26).

This is a truly revolutionary perspective. Where the Greek attitudes to death could be summarised as *welcome it* (classical view), *accept it* (Stoics), or *endure it* (epicurean), Jesus tells us to *fight it*. Jesus fights death and wins the victory in the cross and resurrection: "*He stripped all the spiritual tyrants in the universe of their sham authority at the Cross and marched them naked through the streets.*" (Col 2:15 - *The Message*). This is an image of utter and complete victory, mirroring the parade of defeated soldiers that conquering generals would use to display their dominance in the ancient world.

We see this victory reversing the effects of death at every level in the resurrected Christ (Luke 24:13-35):

- **Body:** Jesus has the disciples touch his body and he eats and drinks with them.
- **Soul:** Jesus is in relationship with his disciples, teaching and talking with them.
- **Spirit:** Jesus prays to his Father, and opens the way to eternal life.

The resurrection reverses the finality of death on every level. Death is no longer the last word, and this is what gives us hope. We are right to mourn those who die, but because of the resurrection we mourn with hope. As Paul puts it: "*Brothers, we do not want you to be ignorant about those who fall asleep, or to grieve like the rest of men, who have no hope.*" (1 Thess 4:14).

> ***"We can face death with hope because we are part of a community who can pray with us and support us."***

Why we Hope

Earlier, we reviewed the finality of death on our bodies, souls and spirits, and how the resurrection reverses that and gives us hope. We now look at seven ways in which that hope is worked out:

1. **Life is seen from an eternal perspective.** Scripture tells us that God knows us long before we are born: "*Before I formed you in the womb I knew you…*" (Jer 1:5), and God will know us long after we die: "*If I go and prepare a place for you, I will come back and take you to be with me…*" (Jn 14:3). We can face death with hope because in Christ our life on this earth is no longer the whole story; it becomes a few pages in a story that started when we were still a glimmer in God's eye and that will continue into eternity when we reign with him in the New Jerusalem (Rev 21).

2. **Death is shared with a community.** Although Jesus often slipped away on his own to pray, we see that when he was facing the crucifixion, he chose to bring his disciples with him to the Garden of Gethsemane, saying: "*My soul is overwhelmed with sorrow to the point of death. Stay here and keep watch with me.*" (Matt 26:38) Three times he asks them to pray with him (even if the disciples are not very helpful!). We can face death with hope because we are part of a community who can pray with us and support us.

3. **We trust in a good Father.** Monica Renz, a palliative care clinician in Switzerland, describes in her book *Dying: A Transition*[3] that those who experience existential distress at the end of life tend to be those who have **not** learned to trust a higher power and to relinquish control. We see positive examples on both these counts in Jesus' time in the Garden where he says: "*My Father, if it is possible, may this cup be taken from me,*" demonstrating trust in his heavenly Father, "*Yet not as I will, but as you will,*" relinquishing control (Matt 26:39). We can face death with hope because we have learned to trust God and to relinquish control to him.

4. **We identify with the crucified Christ.** Death can sometimes be a humiliating experience. I have seen patients with rectal carcinomas who are incontinent due to recto-vaginal fistulas, and those with dementia or brain tumours who have lost their cognition and have to be helped with all their daily cares. We have a Saviour who endured the most humiliating death devised under the Roman Empire: crucifixion was a public spectacle where prisoners were stripped naked (unlike the images of the crucifixion that we are familiar with where there is a loincloth for modesty) and left to hang and die of asphyxiation over hours or days. We can face death with hope because we have a Saviour who knows what it is like to be humiliated, but who shares his triumph with us.

5. **God redeems but does not necessarily reverse our sufferings.** In his resurrected body, Jesus says to Thomas: "*Put your finger here; see my hands. Reach out your hand and put it into my side.*" (Jn 20:27). Despite Jesus being in his glorified and risen body, he still bears the marks of the crucifixion; they are not erased or ignored or written out of the story, as

if the crucifixion had never happened. Though we often wish that God would remove the scars of our suffering or restore things to normal, as if the suffering had never happened, he instead chooses to redeem that suffering and bring something good out of it that we could not have arrived at any other way. The parent who loses a child doesn't have that memory erased but instead grows deeper in empathy and compassion and is able to comfort others with the comfort they have experienced (2 Cor 1:3). We can face death with hope because God doesn't erase, but instead redeems, our suffering.

6. **God has a purpose for us right to the end of our life.** I looked after an older woman with advanced liver cancer who, despite falling into a coma, continued to live for another two weeks before she died. Her husband was extremely distressed during this time and I also found myself asking God what potential purpose could be served by this prolonged demise. One week into her coma, the woman's husband revealed that he had two estranged children whom he had not seen in years. We were able to contact them and one agreed to visit. He and his father were reconciled. When his wife died, her husband now had some support from his son. We can face death with hope because we know that our work for the kingdom is not over until God says it's over.

7. **Our work does not perish with us.** The images of the coming kingdom are described in the book of Revelation: "*Then I saw a new heaven and a new earth… the new Jerusalem coming down out of heaven from God, prepared as a bride beautifully dressed with her husband…*" (Rev 21:1). Two things of note in this verse are that the original Greek for "new" does not refer to the sense of 'brand new' but to 'renewed', and the tense of the verb is the *present* (being renewed) not the future (to be renewed). NT Wright[4], among other theologians, writes that this radically changes our understanding of the coming kingdom. This kingdom is no longer God destroying the world and spiriting us up to heaven; instead, the kingdom is being built **now**, in the present, and every act of kindness and every word of encouragement is adding a brick to the walls of the new Jerusalem, i.e. we are co-workers with God in building the new Jerusalem. Although we can only see darkly now, we will one day see the full glory of creation as God intended it to be. We can face death with hope because our work for the kingdom will not perish, and we will see the new Jerusalem in its glory in due time.

"Therefore, my dear brothers and sisters, stand firm. Let nothing move you. Always give yourself fully to the work of the Lord, because you know that your labour in the Lord is not in vain." (1 Cor 15:58)

References:

1. Verhey, Allen. *The Christian Art of Dying: Learning from Jesus*. Grand Rapids/ Cambridge, Eerdmans Publishing Company. 2011
2. Eco, Umberto. *The Island of the Day Before*. Secker & Warburg (UK)/ Harcourt (US). 1994
3. Renz, Monika. *Dying: A Transition* Col Uni Press. 2015.
4. Wright, NT. *The Day the Revolution Began*. Harper One, 2016.

CMDFA CHRISTIAN MEDICAL & DENTAL FELLOWSHIP of AUSTRALIA Inc

Luke's Journal

www.cmdfa.org.au

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

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Growing In Hope: When God Doesn't Heal

It was five years ago, and I was about to board the Ghan for a three-day train ride home. Mum called to tell me the results of her scan. She had rhabdomyosarcoma – a rare and aggressive cancer. The metastatic lesions were widespread, and she had been given a prognosis of several months to live.

We were shocked because she had been fit and well up to that point. My younger sister was only 11 at the time. Mum remained relatively stable on palliative chemo and radiotherapy until late the following year, when her metastatic lesions began to grow and spread rapidly. She was admitted for spinal cord compressions and passed away – two days after we celebrated her 54th birthday in palliative care.

Angry at God

> *"When the hoped-for, prayed-for miracle doesn't come, when we are not delivered, when there is no miracle, this is the question that hounds us, making sleepless nights endless. Why?"*
> – Ron Dunn, *When Heaven is Silent*

How can a good God allow suffering? This age-old question has been asked since the beginning of time. Atheists frame the argument as this: "*If there is a God, either He is not good, or He is not sovereign.*" In the Bible, Job questions why God is allowing him to suffer. The questions about suffering are not new, but my teenage sister puts it like this: "*When we personally face suffering, it is still a new experience for us as an individual.*"

When mum's treatment did not work despite our daily prayers, I questioned whether the God of the Bible was true and living; I questioned whether He was good. I had been a Christian for many years but felt that the foundations of my faith had been shaken. Prayer was difficult because God neither seemed to exist, nor did He seem to hear or care about our prayers.

Angry at people

We are thankful for the brothers and sisters who walked with us through those years. Yet, at the same time, we often felt disappointed with fellow believers. Sometimes Christians are eager to say something "spiritual" or "positive", rather than stopping to listen and mourn with those who mourn (Romans 12:15). Sometimes people avoided talking at all because they did not know what to say. C.S. Lewis writes about his isolating experience after the death of his beloved wife:

> *"An odd by-product of my loss is that I'm aware of being an embarrassment to everyone I meet. At work, at the club, in the street, I see people, as they approach me, trying to make up their mind whether they'll 'say something about it' or not… Perhaps the bereaved ought to be isolated in special settlements like lepers."*
> - C.S. Lewis, *A Grief Observed*

Sometimes Christians are eager to jump to a diagnosis for the problem. *"You have cancer because you sinned." "Your cancer isn't getting better because you are eating this or that." "You will be cured if you try this specialist overseas." "You need to pray with more faith, then God will heal you."* Undoubtedly the words of advice were said with good intentions, but they were unhelpful.

> *"Now you too have proved to be of no help; you see something dreadful and are afraid."* - Job 6:21

Our desire to explain cause and effect in the face of fear is again nothing

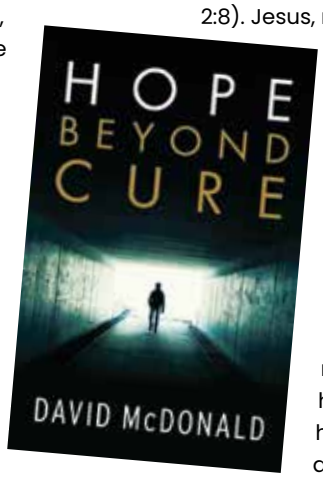
new. Job's three friends attributed his suffering to unconfessed sins, but they were rebuked by God himself for not speaking the truth about God (Job 42:7-9). Jesus warned people against attributing the Galileans' suffering under Pilate to specific sins (Luke 13:1-5).

When God doesn't heal

In our corporate prayer as a church, we pray for healing. At our end-of-year thanksgiving prayer nights, we give thanks for God's protection on our health, finances, and families. Rightly so, for we are urged to pray and give thanks in every situation (Philippians 4:6).

While God is able to heal, we Christians need to acknowledge the reality that God in His sovereignty does not always heal. We see this painful reality clearly in our work in healthcare - where many patients (Christian or not) are neither healed through medical intervention, nor healed via supernatural means. Even Jesus' followers in the Bible are not always saved from death. Paul escaped shipwrecks, snake bites and more (Acts 28) and an angel led Peter out of prison (Acts 12). But Jesus did not intervene in the beheading of his cousin John the Baptist (Matthew 14); neither was Stephen miraculously saved from stoning and death (Acts 7).

David McDonald is a pastor and a cancer patient. In the first few months of mum's diagnosis, she attended his talk at a church in Melbourne. We found this event and his book a great encouragement. He urges Christians to put their hope not in a cure, but first and foremost in the death of Jesus for our sins; and the resurrection of Jesus as a demonstration of God's victory over death (1 Corinthians 15).



"How wonderful is the news that the cancer is gone, that a person has been made well! This is a reason for celebration and rejoicing. But where will we set our hope when the inevitable day arrives and death knocks on the door? God calls us to set our hope on the things to come; he calls us to hope beyond a cure, to hope beyond death. He urges us to take hold of eternal hope by putting our trust in Jesus Christ."
- David McDonald, *Hope Beyond Cure*

Conclusion: growing in hope

If our hope is in Jesus – did he live? Did he die? Was there an empty tomb? How reliable are the gospels? The long process of reading, reflecting, praying, and revisiting the basics of Christianity has been helpful in rebuilding my faith. The Christian faith is historical and robust enough to be examined intellectually. In times of doubt, I was also humbled and comforted to see that faith is not what we manufacture, but is in itself a gift from God (Ephesians 2:8). Jesus, not ourselves, is the author and perfecter of our faith (Hebrews 12:2).

I don't know why God did not answer our prayers for healing. No book and no person - try as they may - can provide a complete and satisfactory answer. In the book of Job, God does not explain why calamities happened to Job and his household but brings Job to a deeper understanding of himself. Through this journey, I am also learning to acknowledge that man cannot fully comprehend God (Job 36:26, Job 42:3). Nevertheless, with the help of the Spirit, we can strive to grow each day in our knowledge of him and the hope we have in Jesus.

"I keep asking that the God of our Lord Jesus Christ, the glorious Father, may give you the Spirit of wisdom and revelation, so that you may know him better. I pray that the eyes of your heart may be enlightened in order that you may know the hope to which he called you ..."
Ephesians 1:17-18

See *Hope Beyond Cure* Book Review on page 12.

Dr Hannah Watts
Hannah is a PGY2 RMO working in Perth, Western Australia with an interest in General Practice.

God's Sovereignty In Our Mistakes

It has been two years since I graduated from medical school and as I reflect on the death of patients and how it has impacted me, I can say the experience has been varied.

There have been times when I have been deeply affected and times where I have hardly been affected at all. However, every patient death is an opportunity to reflect on our own mortality and remind ourselves that, as healthcare professionals, we are not God. We may alleviate suffering and provide healing for a short time, but it is God who is ultimately in control of our lives, and the lives of our patients.

On the one hand I find this a relief, but as a Christian who still has a lot to learn I still find it a puzzling concept to digest, particularly in practice. God says:

> *"See now that I myself am He! There is no God besides me. I put to death and I bring to life, I have wounded and I will heal, and no one can deliver out of my hand."* (Deuteronomy 32:39)

> *"The LORD brings death and makes alive; He brings down to the grave and raises up."* (1 Samuel 2:6)

Passages like these affirm for us the sovereignty of God in all things, including death. Yet we live in a world where our very real decisions have very real consequences. So how are we to deal with situations where it seems as though our decisions have directly led to a patient's death or disability?

The closest I have ever come to feeling like I made a mistake that cost a patient their life was earlier this year whilst working in the Intensive Care Unit at a private hospital. In this Intensive Care Unit there were no registrars, hence on a night shift the unit was equipped with a single resident and the nurses. The Consultant would be called in if required and could always be contacted by phone, however if the patients were not particularly sick the resident would manage things alongside the nurses. On one of my night shifts, the vasopressor requirements of a patient who had been admitted with sepsis slowly began creeping up. The nurses and I troubleshooted together – optimised his fluid status, regularly re-examined him – all the usual. His requirements eventually began to stabilise and there were no other particularly alarming features to make me call the Consultant.

> ***"it is God who is ultimately in control of our lives, and the lives of our patients."***

Finally the shift was drawing to an end. I sat at the computer twiddling my thumbs. The clock was 07:50, only ten minutes until handover. Suddenly I hear the alarm go off on the cardiac monitoring screen. Not necessarily unusual, as when the nurses pull blood from the arterial line it occludes and the alarm usually goes off. Except it is 07:50am and they pull bloods at 6am. That flat line, otherwise known as asystole, is probably real. Just as I register this thought, the internal MET bell goes off. I dash over to bed 12 to find the aforementioned patient with increasing vasopressor requirements unconscious. One nurse is asking me if I feel a pulse. I do not. We start compressions. I start running through the A-B-C-D-E algorithm in my head before remembering that it is for the SICK patient, NOT the ARRESTED patient.

C'mon Hannah, pick up your game, what were you thinking? I slap myself out of that and into the CPR algorithm instead. Thankfully the Emergency Medicine Consultant has arrived and takes over. They ask me to call my ICU Consultant to update him just as the day ICU consultant arrives onto the scene. I reach into my pocket to call him, and with a faltering voice update him on the situation. In my mind I had so many regrets: *Why didn't I just call my Consultant to update him overnight? Was I too proud? Was I trying too hard to be independent? But I thought they wanted us to be independent? What if his vasopressor requirements were a sign of his imminent arrest?*

Thankfully I was spared from my persecutory thoughts the moment my Consultant reassured me that this patient's increasing vasopressor requirements could not have predicted his impending cardiac arrest. I had not done the wrong thing in not calling him. In all likelihood the patient had a massive cardiac event which could not have been foreseen. Nevertheless, the resuscitation was unsuccessful and the patient died that hour.

"Deep down I really do fear that the choices I make will make or break a patient and the burden of my mistakes will rest too heavily on my conscience."

I can still remember the sinking feeling I had in the moment I thought my misjudgement had contributed to the deterioration of that patient, let alone my incompetence at running the resuscitation in the early phases. It was horrible. If I am honest with myself, perhaps that is one of the reasons why I have selected a speciality with seemingly lower stakes involved. Because deep down I really do fear that the choices I make will make or break a patient and the burden of my mistakes will rest too heavily on my conscience. Yet I suppose that is not really trusting in God's sovereignty, is it?

Perhaps as Christians all we are called to do is to humble ourselves before God by dedicating our work to Him in prayer, strive to practice with integrity and thoroughness and then accept the outcome, come what may. Afterall, He is a God who tells us not to fear because He is with us, and promises to strengthen, help and uphold us with His righteous hand (Isaiah 41:10). He is a God who created our inmost being and saw our unformed body, ordaining all the days of our life in His book before any of them came to be (Psalm 139:13-16). He is a God who works out everything in conformity with the purpose of His will (Ephesians 1:11), even the life and death decisions we make in everyday medical practice.

Book Review

Hope Beyond Cure - Dave McDonald

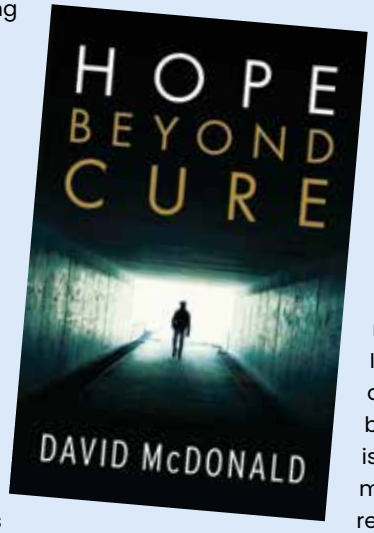
Dr James White

James is a GP registrar in Glen Innes NSW. He enjoys evangelism and the variety of rural general practice. He and his wife Miriam see ministry and medicine as inseparable. They actively encourage others to take the gospel and their skills to rural and remote Australia.

One of the biggest difficulties of being a doctor is that at the end of the day we are only putting bandaids on people's problems.

On the rare occasion where we are actively involved in saving someone's life in the emergency department, we get a real thrill knowing that we were part of something rarer than the general public would perceive. Most of the time we're dealing with chronic illness and an accumulation of life decisions, people's genetics and the capacity or incapacity of the health system to help. What we really want to do is talk to our patients about true hope, about any illness that they're suffering, and it's often difficult to talk about true hope beyond the grave. I've found this book to be an excellent conversation starter, even just with the title, *Hope Beyond Cure.*

This is a great book. I used to carry it around with me whilst doing my internship. A patient with a new diagnosis of lung cancer had many existential questions ... I offered her this book only to be turned down ... ... the next day I was wandering around the hospital only to see this same lady walking towards me at high speed ... "If you've still got that book I'd like a copy!"



Overall, I have found it a very useful book with the only downside being that it is written predominantly from the perspective of the author (who is a church minister)which inadvertently means a lot of the language assumes people are already Christians or have a well-defined belief. This makes it somewhat difficult for non-Christians to read. However I would suggest a revised version for a slightly broader audience as I am sure this would get handed out in hospitals even more regularly. I have not come across another book like it which is why it is still my 'go to' book recommendation when patients are asking existential questions in the context of illness.

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Book Review

To Whom Shall We Go? Faith Responses in a Time of Crisis

This book is a challenging gift from a group of "holy Scribblers" in Queensland (https://holyscribblers.blogspot.com/).

They reflect on the COVID "crisis" (what a tabloid word!) through the lens of their own spirituality, their reflections on the Beatitudes, and their spiritual readings of the sages of the church. There are nine contributors, including academics and spiritual directors, with experience locally and in the Majority World. There are reflections, poems and liturgical prayers to direct our attention to the spiritual resources in Christ, as a support to deal with liminal situations. There are a series of questions for discussion from each chapter which allows for group discussion. I have been very provoked by their engagement in this exercise, for they see things from very different points of view, compared with my own limited perspective. They have therefore broadened me in thinking and praying very differently about the pandemic.

For we all see the same pandemic differently. A common analogy is that the pandemic is the same storm for everyone, but we are in different boats – some are in tiny dinghies, some are in sleek cruise ships. Some are nearly swamped; others barely notice a ripple. How we see the pandemic depends on where we live, our job, and whether we have any dependents living with us. The age and cyber-experience (and access) of the dependents further colours our experience of lockdown. The pandemic is seen very differently according to the competence of our government, whether state, federal or international. It also depends on the size of our nation, and the competence or incompetence of its public health system. The pandemic response depends on government resources, both public health and economic resources, and on our country's commitment to selfishness or to the care of others.

This makes one single emotional and spiritual response to the storm difficult, particularly if that response is seen through the currently spiritually fashionable lens of lament. Yes, we are called to grieve with those who grieve, and we are called to resonate with the deeply tragic expressions in Job, Psalms and Lamentations, especially if there is considerable pain and mourning with the pandemic, but there is also a place for gratitude, celebration and praise, even in the midst of trial.

What are common New Testament themes about trials, other than lament? The New Testament was written in a time of hostility and even hatred towards the Christian faith. This does not mean there were no good people in society (the magistrate at Ephesus comes to mind) but the gospels and epistles are quite clear that followers of Jesus were to expect hostility. Jesus, in the Upper Room discourse, tells His disciples that they will have tribulation in this world, but they are to be of good cheer, take heart, be bold, and trust, for He has overcome the world (John 16:33). In the same discourse He speaks peace to His troubled followers, and He speaks of the joy of being one with Him and with the Father. The writer to the Hebrews in the twelfth chapter is quite blunt in the way in which he encourages his readers: Be inspired by Jesus' obedience in suffering, accept the Father's discipline as difficult but for your good, and pull yourself together, for you have yet to shed your blood (Heb 12:1-17). The disciples in a panic in a storm are confronted with the Master's two rhetorical questions, "Why were you afraid? Have you still no faith?" (Mark 4:40). It is easy to spend a lot of time lamenting our sins and situation when we need to spend more time reflecting on our Saviour and his love and resources.

> ***"It is easy to spend a lot of time lamenting our sins and situation when we need to spend more time reflecting on our Saviour and his love and resources."***

The pandemic has challenged us a lot in the comfortable West. We have had to cope with unpredictability, we have had our dreams snatched away, but has the Christian life not always been one of living by faith and developing resilience in the face of trial?

It is great to see the breadth of spiritual reflection in the chapters, presented.

continued over page.

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Book Review

To whom shall we go? Faith Responses in a time of Crisis

Few would have suspected in 2019 that within just a few months our world would be thrown into turmoil by the COVID pandemic. As Christians we have asked ourselves, why did God allow this to happen? Will we survive? Will our lives ever return to normal and if so, what will that 'new normal' look like?

To Whom Shall We Go: Faith Responses in a Time of Crisis, addresses these questions and more. The authors, most of whom form a group called the 'Holy scribblers', comprise a disparate band of people from diverse backgrounds including medicine, social work, the law, economics, physics, spiritual counselling and missions. Each addresses the question of how to lead a faith filled life in times of this present crisis.

We are encouraged to examine and to adopt the promises of the beatitudes in the context of God's plan for these latter days by the power of His Holy Spirit The disquiet, disturbance and downcast state of our soul reveals an intrinsic yearning for the living God. When we attune our soul to Him, His Spirit comes along side responding to our deepest needs.

We have looked to advice from experts in many fields to guide us through the maelstrom of this pandemic. Yet so often the advice has been conflicting, contributing to confusion, lack of understanding and the generation of a sea of sceptics. Yet the contributors to this book, as diverse as they may be, have sought wisdom from the One who is able to lead us through, and provide the answers that we seek, even Jesus.

I found *To Whom Shall We Go: Faith Responses in a Time of Crisis?* an intensely practical book offering spiritual advice at a level often not encountered nowadays. The words of Jesus, the same yesterday, today and forever will lead us through and beyond this present crisis. As Peter said, 'Where else can we go? You have the words of eternal life.'

I strongly recommend this book to all readers seeking greater insight, direction and purpose as they meet the challenges of today.

To whom shall we go? Gijsbers review from page 13

I particularly valued the chapters based on personal experience of people going through some deep waters. However, I would have liked the writers to have placed a greater emphasis on Scripture. The opening quote is illustrative. The editors have taken the words, "To whom shall we go? You have the words of eternal life…etc" from the Northumbria Community Celtic Daily Prayer, but they did not acknowledge that the words were originally spoken by the Apostle Peter at the end of a long and difficult discourse by Jesus on eating his flesh and drinking his blood. (John 6:69). Likewise, my good friend, Paul Mercer in his excellent reflection on purity of heart describes the "eight deadly thoughts" of Evagrius, as a basis for reflection on purity of heart.

It is instructive to compare Evagrius' taxonomy with Paul's taxonomy of the works of the flesh in Galatians 5. I don't think either list is exhaustive, but Paul's addition of strife, jealousy, quarrels, dissentions and factions, points to a far more communal approach to loving relationships than Evagrius' more personal list. For in spite of the deep emphasis on the closet and time alone with God, in the end Christian love is a corporate exercise expressed and experienced in community.

I would have liked to see more emphasis on the positives of the covid "crisis". It has exposed the weaknesses of our current society, the lack of affordable housing, the casualization of the workforce, and the problems of privatization of the public service, but it has also shown the possibilities of greater flexibility in working from home, the cancellation of the frantic lifestyle for a more leisurely pursuit of family life, and the opportunity of showing greater care and compassion for one another. We have become masters of Internet communication with further shrinking of the tyranny of distance. As an added bonus it has shown how bogus the 45th president of the US has been, and how this has led to appropriate judgement on his appalling leadership.

This book is provoking, worth reflecting on and praying through. There is a lot more to it than this short review can compass and I will continue to think and pray through each of their chapters. I thank my colleagues for making it available to me.

Dr Joel Winney
Joel is a junior doctor based in Sydney at Concord Hospital. He graduated in 2019 from the University of New South Wales and has completed his recent intern year almost entirely during the current COVID-19 pandemic.

Death, Dignity and the Decisions that Trouble Us

A Pandemic Perspective

"Quick, call his wife to come in!"

"What should I tell her?"

"What do you mean?"

"Well, is she even allowed to come in to see him? She's supposed to be self-isolating and has no way to get here without exposing someone."

"Just call her. She should come in. He's not looking good. We'll figure out the logistics."

That was the conversation, as I remember it in my head at least. It's all a bit of a blur. To be honest, it was more like fifteen or twenty conversations by the end of the night - a dozen phone calls with at least three specialists, infection control, and the hospital executive. And then there were three other doctors and myself, all trying to work out what to do when the one thing that *should* be allowed to happen for the patient before us *isn't* allowed to happen.

He was dying you see. That was the most obvious conclusion. As for how that would take place, that was far less clear.

The Day Reality Set In

The instinct to call a patient's family to be close by when their loved one is near death's door is very fundamental. It is certainly tragic when you are required to be the messenger of such a call, still worse for the person receiving the call. However, as a junior doctor, I have found that it feels like one of the most beautiful human things you get to do when working in a hospital. You are entrusted with being the bearer of bad news and helping shoulder the grievous burdens of those hearing it. It is a careful and precious moment to be dealt with sensitively and compassionately.

Yet, on this night I found myself at a loss when asked to pick up the phone to call the family of a rapidly deteriorating patient. He was an elderly gentleman with little to no English, and his breathing was becoming increasingly laboured. He had recently arrived home together with his wife from Hong Kong. Soon after his return, he had fallen ill with a respiratory illness. I was first introduced to him in a flurry at the start of another night shift. Everyone wondered if he might have COVID-19 (all signs pointed in that direction) and in his current state he probably wouldn't last the night.

> ***"You are entrusted with being the bearer of bad news and helping shoulder the grievous burdens of those hearing it."***

As a matter of good public health policy, his wife was now isolated at home as a close contact of a suspected case. But right at this moment, at the time when her husband was close to death, good public health policy felt like awful patient care.

As a junior doctor, this was the first time I'd come face to face with the decisions that mark the dying process under the shroud of COVID-19. Like an invisible wet blanket, all of a sudden every good intention and desire was snuffed out by the need to weigh and re-weigh infection risk; to avoid potential spread of the virus to otherwise unknown people; and to find my (as yet undefined) role in simultaneously caring for individual patients and also the community at large.

Competing Interests - The Individual vs The Community

By now, for most healthcare workers, I'm sure the competing responsibilities to individuals and communities in the midst of the COVID-19 pandemic have been brought to bear in some way, shape or form.

There exists an often-times counterintuitive tension between acting in a way that most benefits the common good, whilst also doing no harm to the patient at the bedside. Although as a junior doctor I'm reluctant to make firm assertions on this, it seems that within the context of this pandemic, public health ethics have largely been aimed at reducing harms while maintaining proportionality - keeping in view a primarily consequentialist approach to decision-making. To do this we use our best estimates of the epidemiological risk within a community and work backwards from there.

In this case, this man and his wife were at 'high risk' of having SARS-CoV-2, both because of their recent travel history and this man's symptom profile. And so to allow this man's wife to come to the hospital via the taxi she would inevitably need was tantamount to promoting the spread of the disease - both along the unassuming taxi-driver's course that night, as well as putting the taxi driver himself at considerable risk. It was untenable and I was told that in no uncertain terms.

Many of us healthcare workers, myself included, sit at least one or two steps away from where that decision-making occurs. We are merely conduits of received wisdom handed down from the powers that be. That was the case when we had to tell this man's wife that she must not under any circumstances get in a taxi, or on a bus, to come to the hospital. Her family would have to weigh up the risks and take her if they were willing and then self-isolate for two weeks as yet another close contact.

We operate under the assumption of trust in the moral integrity of otherwise-unknown decision-makers and stakeholders in our local health areas. Whilst not being privy to the motives behind policies for infection control or visitation may irk some of us, I myself am buoyed by the long heritage of Christ-inspired and Christian-influenced virtue upon which much of our Western healthcare system stands.[1]

Thankfully, here and in most healthcare settings, public health decisions are typically made with a view to providing exceptions in order to preserve virtue ethics such as beneficence, justice and respect for autonomy. At no point was the desire for her to see her husband ever called into question. The logistics of fulfilling that desire were the impossible hurdle to get over.

"Many of us healthcare workers, myself included, sit at least one or two steps away from where that decision-making occurs."

However, here in this season, I am reminded that in the Scriptures we are nowhere absolved of our civic duty to our broader communities (1 Thessalonians 4:10-12; Jeremiah 29:7). Nor do we have the liberty to ignore the suffering of the individuals whom we meet on our way (Luke 10:25-37). To hold these together is the present difficulty.

So what of people who are dying?

I have seen this year an unspoken but implicit understanding that the last moments of life carry profound significance. As a Christian this is readily understandable as a common reckoning that eternity is written on the hearts of all.

> *"He has also set eternity in the human heart"*
> *Ecclesiastes 3:11*

It is not surprising then, that each and every person we encounter wishes to be known and loved, and have their dignity preserved, even up to (and perhaps especially at) the point of death. They understand the value of life and the common grace of God that persists to the very last moment.

So, for the individual, as well as doing no harm and seeking their good, there is also a righteous requirement to preserve the dignity of those who are in their last hours or days, and to provide connection with their nearest and dearest.

The Labour to Preserve Value

As an intern, this year I spent more time than I anticipated on the phone. Calls were made to state public health units, embassies of various nations and to family members stuck in quarantine trying to arrange for family to be close to dying relatives. Alongside some phenomenal social workers and other health staff, letters of support for travel exemptions, emails to administrative and executive hospital staff, and other seemingly mundane tasks all served to promote the wishes and values of our individual patients.

One encounter with the wife and son of another patient was particularly illuminating. During a long illness course, I looked after an elderly gentleman for the better part of six weeks. Over the course of his stay it became clearer and clearer to us and to him that he would slowly decline due to very severe emphysematous disease. He wished to see his son, who at the time was under lockdown in Melbourne. So I wrote a letter of support for his son, gave it to the family to go through the appropriate channels and went on my way. At the time, it did not seem like a big thing at all.

The son's request to travel was rejected, and his father eventually passed away - a grief many have sadly had to face this year. In the final days of caring for him, his other son (who was able to be present), a lovely Christian man, thanked each person involved in his father's care. I was surprised when he thanked me specifically for trying to help his brother to come to see him. He was not angry at the request being denied or my unsuccessful attempt to help. Rather, it seemed he was moved by the labour to

give value to the things most important to his father and his family.

It seems, therefore, that whether it be making provision for family members to visit, providing for spiritual needs, preventing unnecessary physical suffering, or the myriad other components of good quality end-of-life care, it is the image of God in man - that intrinsic, unquantifiable value gifted to us in creation - that ought to be loved and cherished. And it is our high and holy privilege as health workers to do so, even at the same time as we contend with the pandemic before us.

The Hidden Toll of Our Decisions Around Dying

These decision-making processes are rarely as simple as we wish them to be. It would be remiss not to mention that there are untold costs and harms to our decisions that are almost impossible to hold together at the same time, and of which we may not readily see the effects. I have been mindful of the delayed consequences after the 2011 earthquake and tsunami that affected the east coast of Japan. Whilst the immediate damage and death toll was profoundly felt, it wasn't until two, three and even five years years later, that related rises in the rate of cardiovascular disease and suicide deaths in those evacuated from the area were seen.[2,3]

In regard to this pandemic, it still saddens me that the first-mentioned man's wife, rather than being able to focus purely on comforting her husband, had to contend with a force of doctors, nurses and administrators who (it must have appeared) were trying to prevent her from doing that very thing. It still saddens me that the later-mentioned son never got to say goodbye to his father in person. For these and many other events of this pandemic, it has been a point of seeking God's grace and comfort for harms outside my control, and forgiveness for those sins of which I am as yet unaware (Psalm 19:12). I pray for His mercy in the years to come as we deal with the aftermath of deferred grief and undignified deaths.

It strikes me as instructive that Jesus was at one and the same time the feeder of

thousands (Matthew 14:13-21) and healer of individuals (Mark 5:25-34). He was the teacher of many (Matthew 5-7), and the justifier of one (John 7:53-8:11). In the face of death he spoke for the crowd's benefit (John 11:42) and wept with the sister of the deceased (John 11:33, 35). So I think it appropriate that we are to aim to do the same. Learning to hold these competing values in tension this last year has been both a challenge and a joy of profound significance.

Reflecting On This Holy Privilege

We never did find out if that first gentleman had COVID-19 or not. But I still remember his face. Behind the mask and oxygen supply, he had the weary and well-told eyes of an elderly gentleman whose body had suffered all but its final onslaught. Although it was complicated, messy and unsatisfying in its brevity, a way was found for his wife to see him. There was no question in our minds that, although it looked different to how we might envision it with time limits and personal protective equipment and the rigmarole of it all, his dignity would be best protected in death by his being near the wife he had loved for so many years. Stories of family members talking over a video call or singing to their loved ones over the phone have a similar weight.

And so I am reminded that despite the volume and complexity of decision making that must occur in this season, particularly around the dying process, there exists a dignity in each patient that must be preserved, must be upheld. It is a dignity that is intrinsic to each person, made in the image of God, and therefore worthy of our advocacy and labour for their benefit.

But I do not decry that this peculiar and precious labour of caring for the individual feels at times in tension with the curtailments of broader-based policies and generalised ethical frameworks that don't meet every individual requirement. So long as these big-picture frameworks are just and compassionate, and we are free and willing to advocate for our patients, this seems to me for the most part like a dance where the push and pull of the desire to protect and care for one and for many must find its rhythm.

The prophet Micah's summary of the law captures it well:

> *"He has shown you, O man,*
> *what is good;*
> *And what does the Lord require of you*
> *But to do justly,*
> *To love mercy,*
> *And to walk humbly with your God?"*
> *Micah 6:8*

We are called to love mercy, and so desire the good of the individual before us. We are to do justly, and so perform our civic duty with more than merely the individual in mind. And we are to walk humbly before our God, trusting His providence and seeking out wisdom for each and every one of these difficult circumstances. This we are called to do with patience and integrity throughout our whole life. And in death, it seems that this makes all the difference.

References

1. *The origins of Western healthcare - Centre for Public Christianity*. Centre for Public Christianity. (2021). Retrieved 13 January 2021, from https://www.publicchristianity.org/the-origins-of-western-healthcare/.
2. Orui, M., Suzuki, Y., Maeda, M., & Yasumura, S. (2018). Suicide Rates in Evacuation Areas After the Fukushima Daiichi Nuclear Disaster. Crisis, 39(5), 353–363. https://doi.org/10.1027/0227-5910/a000509
3. Ohira, T., Nakano, H., Nagai, M., Yumiya, Y., Zhang, W., & Uemura, M. et al. (2017). Changes in Cardiovascular Risk Factors After the Great East Japan Earthquake. *Asia Pacific Journal Of Public Health*, 29(2_suppl), 47S-55S. https://doi.org/10.1177/1010539517695436

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On Dying, and a Hope-filled Death

Some months ago, I accepted an invitation to write an article entitled *Dying a hope-filled death* for *Luke's Journal*, a journal focusing on integrating Christian faith and work in healthcare. As I mulled over this topic, I sensed a disconnection between the subject and the journal's readership. Let me explain.

Death is the ultimate act of differentiation, a journey that we must take physically, alone, as we decay and return to the dust from which we came. Our body will continue to disintegrate until only earthly elements remain. Death is a final frontier. On a palliative care team, a chaplain spends time accompanying patients as they process emotional, existential and spiritual aspects of a terminal illness, helping such people ponder their own mortality and the agency and choices that are still open to them as they move towards their own death.

In contrast to this closing down of death, hope is a window to the future and contains the possibility of even transcending death in some belief systems. In everyday usage, hope has many horizons; some are nearby, others lie far into the distance. We hope for safe travel, alleviation of pain, to see children grow up, health, to spend time with family and friends and at the far horizon – a life beyond death.

From a Christian perspective, this hope is expressed even as we die physically; we confidently live with a spiritual hope, believing that those who die in Christ are being inwardly renewed. For a follower of Christ, maturing towards death is the final step in our faith journey. Death will strip us of all that is corrupt – our decaying flesh, sin, evil, and the pain and suffering of a broken world – everything that stands between us and seeing God face to face.

Yet, only the sufferer themselves can attend to the matters that will ensure a hope-filled death despite the genuinely emotional, existential and spiritual pain of a decaying and disintegrating mortal body. All others around the sufferer are constrained and held back by life. The ministry of the living is to accompany and guide the other to the boundary of life, pointing at the signposts that lead to the journey beyond.

> ***"The ministry of the living is to accompany and guide the other to the boundary of life, pointing at the signposts that lead to the journey beyond."***

So, what might a Christian chaplain say to Christian physicians – those accompanying others to the boundary of life, about "dying a hope-filled death"? In truth, we are limited by our finite mortality, and we have no power given to us to bring about a hope-filled death for another – this is a power that alone belongs to the God of the living and dead. But as followers of the risen Lord Jesus, we live hope-filled lives, full of salt and light of which Archbishop Cranmer noted, "a true faith cannot be kept secret, but when occasion is offered, it will break out, and show itself by good works."

A Christian physician, like all Christians, lives life within a complex matrix attending to both the vertical and the horizontal. Our lives are contextualised by a love for God and a love that extends to all others – the widow, the orphan,

the foreigner, the alien, the sufferer and even our enemies. As a physician, you do not need to go looking for people to love. God brings all kinds of people who suffer and are afflicted to the hospitals and hospices where you work. One can be reasonably sure that care of your patients is a subset of the good works that God has prepared in advance for you to do.

Our Christian faith holds that each person is created by God and loved and known by God, and each bears the image of God. When we are truly present to a person, we afford them dignity. To be present, is to give the other our undivided attention for the time we are with them. In the words of St Ignatius, we are willing to take 'a long loving look at the real' – the real person and their actual situation.

What does it mean for a physician to *really* love a patient undergoing palliative care? In First Corinthians, St Paul tells us that *"love is patient; love is kind. It does not envy; it does not boast; it is not proud. It does not dishonour others; it is not self-seeking, it is not easily angered, it keeps no record of wrongs. Love does not delight in evil but rejoices with the truth. It always protects, always trusts, always hopes, always perseveres."* (I Cor 13:4-7 NIVUK)

If we apply this Christian love to a physician's role with a patient, we might discern that the physician is operating out of two intertwined roles; the first is that of the physician, the professional exercise of the medical art of palliative care, its possibilities and limits. Professionally, a hope-filled life offers holistic medical care that honours the sufferer. The sufferer's life is dignified when medical care is truthfully aligned with God's love reflected in best practices that avoid self-seeking ambition, annoyance, envy or pride, and the capacity to persevere through difficulties to protect the sufferer's God-given humanity. Fortunately, palliative care is a team discipline, and we share the load as fully as possible within the multidisciplinary team offering palliative care according to the patient's wishes.

The second role is that of a person, where we operate out of what Christians for centuries have called our soul, the seat of our personhood. When operating out of our soul we have both the freedom to be ourselves while respecting well-defined professional boundaries. If we accept this, we can see that there are professional and personal aspects of love. It is out of the personal element of love that hope flows. A hope-filled life has the potential to overflow with patience, kindness, trustworthiness, and grace. Yet, we might wonder where this wellspring of hope resides.

> ***"When you bring your living soul close to another soul, your love, kindness can be experienced. By this in our human souls, we imitate our Lord."***

Jesus offers a metaphor to help explain. He describes Himself as the vine and us as the branches of the vine (John 14). He implores us to remain in him as he remains in us. He flows to us as *xylem* and *phloem*, the vine's lifeblood or Christ's Holy Spirit, flows through us. As we remain in Christ the vine, the Holy Spirit produces good and hope-filled fruit in our lives. In Galatians, St Paul explains that the fruit of the Spirit in the lives of Christians is seen through the actions of love, joy, peace, forbearance, kindness, goodness, faithfulness, gentleness and self-control. (Gal 5:22 NIVUK)

There is a significant overlap between the list of love from Corinthians and the fruit of the Spirit. Both lists include ideas of self-discipline and restraint expressed in terms of patience, forbearance and perseverance, and self-control held together with other concepts of moving towards another expressed as kindness, gentleness, and protection, but perhaps most clearly embodied in kindness.

Between the physician and the sufferer, there is a mingling. That of the hope that flows out of the soul of a genuinely kind and loving person and the dignified care of frail bodies that leak and no longer work as they once did.

Theologian Kirk Patston speaks of our human frailty as leaky bodies. Kindness moves us towards the care that quietly, patiently, lovingly mops up leaky bodies. Bodies leak. Bodies may bleed, ooze, cry tears of joy or sorrow, urinate, defecate, vomit, and dribble. And with infirmity, we increasingly lose control of bodily functions. Kindness is a connection between two unmasked souls, the sufferer whose physical mask is disintegrating before them and the carer who chooses to emerge from behind their professional mask to care from out of their soul.

For each of us, our human soul is not separate from our leaky body. Our soul is embodied, and the body is ensouled. Souls communicate. They communicate deeply through silences, words, metaphors, images and groans, gestures and expressions. Created human souls are created to connect with the Creator. Our soul cares about meaning and belonging, hopes and fears, life and loss, suffering and love, it is out of our soul that we pray.

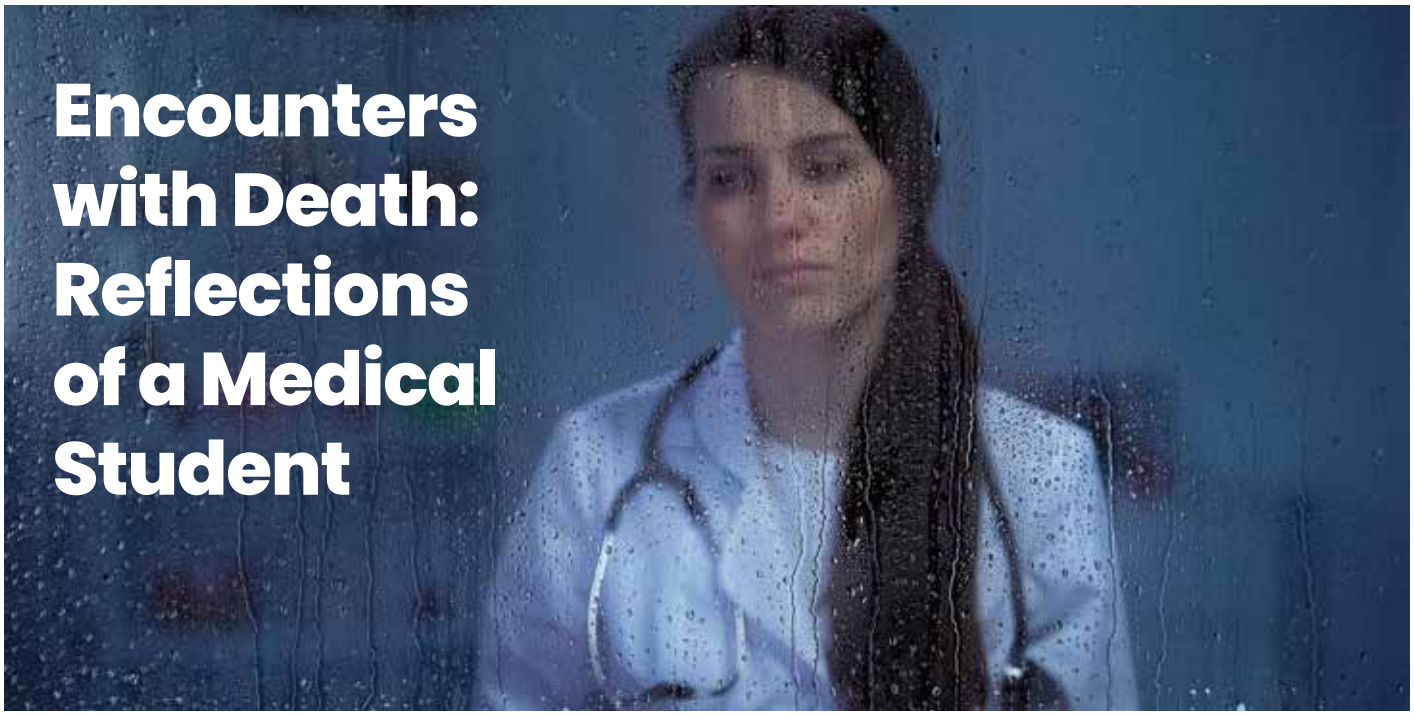
When you bring your living soul close to another soul, your love, kindness can be experienced. By this in our human souls, we imitate our Lord. This intermingling of hope and bodily suffering resembles the ultimate intermingling of lovingkindness with the breaking of a body, and the spilling of blood, by our fully human and fully divine Jesus Christ on the cross.

In Christ, we live hope-filled lives. Our hopes for those in our care are expressed through prayer, in the love that extends dignity to all patients and the kindness we show to each person. When your voice is gentle, your breathing relaxed, your manner non-defensive, and your presence kind, you offer safety and engender trust. The other person may feel safe enough to allow their soul to connect with yours; you are accompanying them a little on the way of their journey, and they are accompanying you on the path of your journey – your souls, for a time, mingle.

Living hope-filled lives helps to fill those dying with hope.

Ebony Remyn
Ebony is a final year medical student at Monash University. With a Graduate Diploma of Divinity completed last year she has an interest in observing the intersections between faith and clinical practice.

Encounters with Death: Reflections of a Medical Student



I was surprised during my first few weeks of clinical placement at how infrequently I heard about people dying. I had a perception that hospitals were full of death, yet everyone seemed to be sent home in a better condition than when they arrived: death postponed for a little longer.

Recently I completed a palliative care rotation and have had time to stop and reflect on how this exposure to many deaths during my clinical placements has affected me. Placing this in the context of holistic care, coupled with my Christian faith, has helped me to process these events.

As the years of my medical study progressed, encounters with those near the end of their life inevitably came, however not in the way I had previously imagined. I still have not been at the bedside of a person taking their last breath. Yet encounters with the dying have made their impact on me.

Of course, the first encounter with a dead body for many medical students is using cadavers for anatomy teaching. The caution and uncertainty of the first day in anatomy lab quickly turns to a respectful normalcy. Yet in this environment the personal story of the person who has donated their body is removed. We can learn about their medical conditions through our findings, while their personal stories remain a mystery.

During clinical rotations, this scenario is reversed. Now, the story is more clearly known. I have had conversations about hobbies or favourite movies and met with family and friends of many people who have since passed away. This reversal, not necessarily seeing the person after their death and yet knowing so much more about them personally, is disconcerting.

My interactions with patients towards the end of their lives have manifested in many ways:

- I have experienced uncertainty and discomfort as a patient joked about being ready to die.

"psycho-social and spiritual support is recognised as an integral part of care"

- Curiosity about the palliative care room at the end of the hallway that the medical team seldom visited during ward rounds.
- Frustration at the hospital politics and under-resourcing in the public system that left some rural patients stuck in a hospital that could not care for their needs rendering them unable to eat: a nasty physical reminder of the human cost of the bed pressure and under-resourcing in the healthcare system.
- Respect and sadness for families journeying with their loved ones through a defining period of life.
- Dismay at the inexorable course of a lady with ongoing complications after a complex surgery.

As I have advanced through my clinical years, I have experienced the irrational hope and feelings of helplessness as I performed CPR in an emergency department on a child who was dead before the long ambulance ride that took them to hospital. My brief hope that spontaneous breathing resumed was dashed as I realised

it was the doctor ventilating the intubated patient. Just a couple of weeks earlier, I was present while a mother gave birth to a child whose twin had died in utero. It was strange celebrating the healthy delivery of one child with the parents, while the other was also in the room, in a surgical tray, lifeless.

Now having recently completed a palliative care rotation I have had the privilege of journeying closely with people as their life comes to a close. The calm, reassuring environment of a specialist palliative care ward allows all aspects of the dying process to be fully addressed. Patients' symptoms are ameliorated, and psycho-social and spiritual support is recognised as an integral part of care. A special dignity is granted to all who have been carefully looked after.

This emphasis on the psycho-social and spiritual aspect of care needs to be embraced personally by students and junior doctors as they inevitably have repeated encounters with death.

"Even the creator of this world laments the presence of death ..."

Without the social support of friends and family, the suffering associated with death would have become overwhelming for me. I have found great comfort in the informal debriefs that spontaneously happen within groups of students and doctors reminiscing about memorable patients, or lamenting circumstances that have led to poor care or deaths.

Furthermore, an eternal perspective helps to contextualise these deaths. I have found reassurance in sharing Jesus' reaction to Lazarus' death (John 11:35, 38) recognising the sadness and difficulty of this aspect of life. Even the creator of this world laments the presence of death in this world. Death is such a stark reminder of the consequences of the Fall (Genesis 3:22). Yet we have the comfort of looking with anticipation to a future where there will be no more death and tears, in the eternal presence of the greatest healer of all time (Revelation 21:4).

Luke's Journal

www.cmdfa.org.au

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

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

Luke's Journal Back Issues

Back issues can be accessed electronically at lukesjournalcmdfa.com or on the issuu app at www.issuu.com
Please email the national office for a photocopy version. This is free for financial members of the CMDFA or at a cost of $20 for non-members. Payment details can be requested from the office at office@cmdfa.org.au or 02 9680 1233.

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A Personal Perspective of Experiencing Grief in Lockdown

Everyone's experience of grief is unique and personal. We each have different roles, personalities and relationships with the one who is passing away.

My experience of the death of my mother is unique – not even my twin sister shares the same emotions or responses. But it is made more unique due to the fact that she died during COVID lockdown.

So what does grief and loss look like during such a difficult time? For myself it was surprisingly positive – if that's the right word. God was very real during the whole experience reflecting his light in the dark months of suffering.

My story begins in March of 2020 just after NSW went into full lockdown. That was when my family in England first became aware there was a health issue with my Mum. It started with a sudden change in behaviour, short term memory loss and repetitive questions about the dog. (Tessa had died 15 years before). It was not looking good. Medical tests revealed brain cancer and her diagnosis was terminal.

So, picture this – my terminally ill mother was in the UK and needed around the clock care. Her wish was to stay at home until she died. The alternative was COVID affected palliative care in an NHS hospice, which would mean only one visit of one hour a day by the same masked and gowned person each day. I live in Newcastle, NSW with my husband and family. We had both trained as physiotherapists, and I now work in aged care/palliative care as a pastoral carer.

Who would not want to travel over to care for her?

I have to say, the NSW government didn't make it easy to get permission to fly – but it was in the middle of a pandemic and the fewer people travelling meant fewer returning travellers with the virus. So I understood. I persisted with multiple applications for 3 weeks and in the end, both myself and my husband were granted permission to travel. We flew out at the end of May, not knowing how much longer she had left. But we were very grateful we were allowed to go.

> ***"All the time we were aware that every person who entered the house could have the virus."***

Deserted airports, immigration officers and police made the departure from Australia feel like an alternative reality. Having to wear face masks for 23 hours on the plane added to the strange experience, which was compounded by air hostesses in full PPE. Meal times were tricky, as you can imagine!

But arrival in Heathrow Airport felt like we had come from a continent that was completely over-reacting. We were waved through without any more issues than usual at immigration. We were told to spend 14 days in home quarantine on arrival but nobody checked up on us in all that time. Even my family was not concerned about our possible contamination post international travel. They didn't wear face masks or request that we did. We felt like we had arrived from another planet!

My mother was pleased to see us both and was able to express her gratitude that we had arrived. She was aware that the virus was affecting the world and that

life was no longer the same. However, she quickly forgot that we had just had that conversation and was surprised and delighted each time I told her I had come to stay. This may seem like a simple statement but to us both it was little short of a miracle. You see, mum was an alcoholic. She had struggled with alcohol for as many years as I can remember, although I didn't realise the cause as a child. But I grew up walking on egg-shells, dealing with unexpected outbursts and withdrawal, watching my parents marriage slowly collapse. She was emotionally remote as a mother, which I have struggled with for years.

So to experience her greeting to us both was an unexpected blessing. God in His mercy seemingly allowed brain cancer to bring my Mum to a place where she seemed to be able to relate warmly with us after all those years.

Practically speaking, my father was at the end of his physical and emotional capacity after navigating the complexities of palliative care at home. The local hospice was great at giving advice and support by phone but wasn't able to visit, which wasn't ideal. The homecare agencies were able to provide daily care but could only help at set times in the day. We provided all the other care, day and night. At first, it wasn't too difficult as Mum was able to walk around and explain what she wanted. But she deteriorated rapidly during the next 2 weeks, and before long we were dealing with total care. We took turns sleeping near her bed as in her confusion she would try to get out of bed at random times through the night. It was exhausting. My sister came down from Manchester to help us out which was another blessing.

And all the time we were aware that every person who entered the house could have the virus. Every shopping trip we felt the burden of bringing the virus back into the house to both Mum and Dad. It added a depth of stress that we didn't need at the time, like a spectre that loomed at the edges of our consciousness.

It was during this time that I decided to

write my own personal psalm, based on Psalm 22, to share my fears with God in a personal way. I was conscious that my hands were the means of transmission and yet were also the way I was reaching out to care for my mum. How could I show God's embodied love in a time of intense suffering and fear?

Covid Psalm

My God, my God,
why have you forsaken me?
Why has my world changed beyond recognition? How long must I suffer?
Why, Lord, are so many in fear of their lives, while others mourn for a loved one taken so suddenly?
I've lost my ability to sleep soundly.
My dreams are shaped by fear,
by unknown assailants.
I toss and turn all night.
My days are driven by uncertainty,
By a search to find a sense of normal again.
I long for comfort, for routine, for the chance to enjoy the company of family, friends, and hugs.

How can I trust in you, Lord, In your loving care, when the Covid virus appears so random, so uncaring, not respecting age or status.
How can I trust you have my life in your hands – when hands are a means of giving this disease?

And yet, I know that your Son died to conquer death itself.
He suffered as I suffer.
He was isolated from all friends and family as he chose to die on a cross.
He knew the certainty of death, and chose that path willingly, on my behalf.
His hands were pierced – no longer able to reach out to grasp others' hands.
But his sacrifice was the ultimate act of love.
I know my short time of isolation and denial is nothing compared with your suffering, Lord.
And I know you reach out your hands, pierced for me, to grasp as I stumble through this strange time.
Pick me up, dear Father, lead the way and assure me that you have purpose beyond my understanding, as I trust in you.

My cry to God was answered in small but profound ways. The situation we found ourselves in allowed us to care for Mum in a really personal way. We were aware of her every need and were able to respond in a way that respected her personality and values. I was able to play some of her favourite hymns for her which we sang along together. For the first time in my life I was able to make her a cup of coffee which she reached out and accepted with a smile. My hands were a means of offering love and forgiveness. Her hands reached out and accepted in gratitude. She was grateful for our help and her acceptance helped heal past resentments.

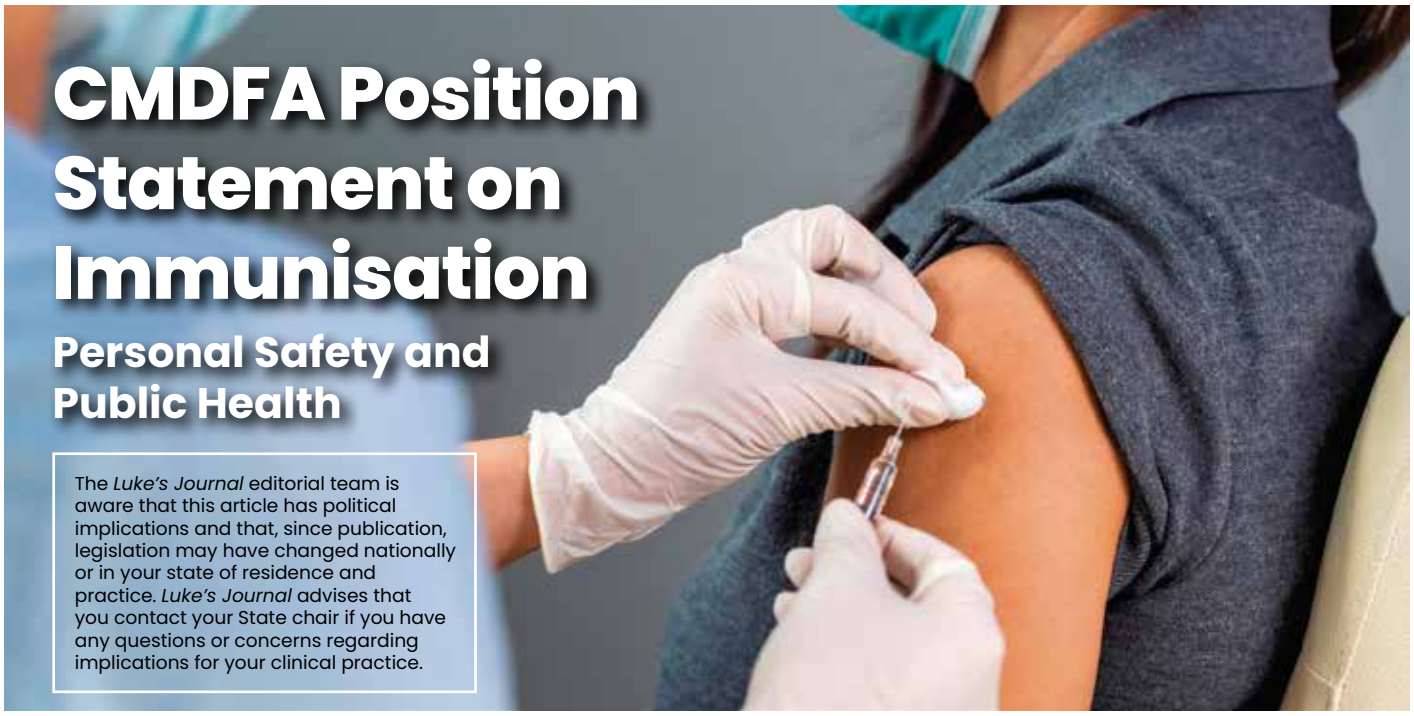
As I reflect, I can see that it is the small, shared experiences that made a difference, helping build bridges in our broken relationship. Without the need to care for her at home, we wouldn't have had the opportunity to share these times with her. The medical help we received was a helpful means to allow this to happen but didn't dominate the experience. It was the holistic palliative care experience I would wish for everyone in their last days.

When my Mum finally died, it was after a day of agitation, pain and confusion that was extremely distressing for us all. The palliative care support we received from the on-call nurses was amazing. They quickly provided much-needed pain relief so we were able to navigate the final hours with some sense of coping.

Continued page 37.

CMDFA Position Statement on Immunisation

Personal Safety and Public Health



The *Luke's Journal* editorial team is aware that this article has political implications and that, since publication, legislation may have changed nationally or in your state of residence and practice. *Luke's Journal* advises that you contact your State chair if you have any questions or concerns regarding implications for your clinical practice.

Since the pioneering work of Edward Jenner and others in developing a vaccination for smallpox over 200 years ago, immunisation has been of great benefit to individuals as well as the public. Immunisation practices have prevented outbreaks of communicable diseases and resultant deaths or disability and continue to prevent an ever-increasing variety of illnesses.

The immunisation process is based on safely activating the body's own defence system against a specific disease. As with any medical treatment, it carries a small but real risk of an adverse reaction.

CMDFA agrees with current medical opinion that immunisations are of great benefit to the individual and society. The decision to immunise an individual relies on the similar decision-making process used for that of any other medical treatment.

CMDFA recognises that immunisation benefits society by protecting public health and that individual members of society have some reciprocal obligations to the society in which they live. For an immunisation program to be successful, a large majority of the population (usually 85-95%, depending on the infection) must be vaccinated in order for 'herd immunity' to be reached, indicating that vulnerable members of the population will have minimal exposure to the infection. If many members of the public have concerns about the ethics of vaccination and refuse it, then it could become a serious public health problem.

CMDFA acknowledges the right of an individual to refuse immunisation except in extraordinary public health circumstances. This decision may be motivated by moral, personal or religious convictions, known risk, misinformation, or fear. The Christian community needs to base its decisions on accurate information, such as that obtained on government websites. Those who model their lives in imitation of Christ should reflect on their obligation to take personal risk for the good of others, or for the common good.

"Does acceptance of the COVID-19 vaccine represent endorsement of abortion?"

CMDFA supports the current scientific literature that validates the general practice of immunisation as an overall safe, effective, and recommended procedure.

Immunisation and Potential for Moral Complicity with Evil

The use of medical information and technology obtained through immoral means raises concerns about moral complicity with evil. **Some currently available vaccines were developed using human cell lines developed from aborted foetuses.** We need to consider carefully whether it is morally permissible to benefit from knowledge or technology obtained from the intentional destruction of human life.

We attempt to determine whether our participation is appropriately distanced or inappropriately complicit by consideration of the medical facts and our conscience as informed by the revealed Word of God.

CMDFA provides the following examples to help determine whether it is

permissible to manufacture, administer or receive a specific vaccine:

- Using technology that was developed without any intentional destruction of human life or any other evil is morally ideal. To date, many vaccines in use fall into this category.
- Using technology developed from the tissue of an intentionally aborted foetus, but without continuing the cell line derived from that foetus, may be morally acceptable.
- Continued use of a cell line developed from an intentionally aborted foetus poses moral questions and must be decided as a matter of conscience, weighing the clear moral obligation to protect the health of our families and society against the risk of complicity with evil.
- Using a vaccine that requires the continued destruction of human life is morally unacceptable.

CMDFA encourages the use of and endorses the further development of medically effective and ethically permissible alternatives that do not raise the question of moral complicity.

> ***"It could be argued that to refuse vaccination ... would also be wrong as it ... is not a loving way to treat our neighbours."***

Addendum: Ethics of the COVID-19 vaccine

Does acceptance of the COVID-19 vaccine represent endorsement of abortion?

Some COVID-19 vaccines are designed, manufactured and/or tested using tissue from a human cell line which is derived from an intentionally aborted foetus, such as the AstraZeneca vaccine. A key consideration for many Christians is whether using such vaccines is permissible or immoral is whether there is material cooperation with the act of killing that foetus. If the abortion was conducted in order to harvest tissue specifically for the vaccine, then it would clearly be immoral. But in the case of the COVID-19 vaccines created from fetal cell lines, the abortion was carried out for other reasons, and the tissue was acquired after the child's death for the purpose of medical research. The use of the vaccine now will not promote further abortions for this particular purpose. It can therefore be argued that we are not morally complicit with the original abortion.

It could be argued that to refuse vaccination (in the event that only an unethical COVID-19 vaccine were available) would also be wrong as it increases the risk of prolonging the pandemic and is not a loving way to treat our neighbours. When comparing the competing ethical obligations of avoiding the vaccine in view of the wrong done in the past or refusing to protect the vulnerable in society today, it could be argued that the latter is the more immediate responsibility.

On weighing these arguments, while recognising that this is an issue of individual conscience, **the CMDFA encourages participation in current Australian COVID-19 vaccination programs.**

Endorsed by the Ethics Management Team of CMDFA on 24 March 2021

Approved by the CMDFA Board on 15 April 2021

Calling Trainers of the Saline Process

As Trainers of the Saline Process, would you kindly reflect on the privilege of being part of the expanding the Kingdom of God by equipping witnesses?

Would you pause for a moment and think of a world where every healthcare worker is passionate to share Christ and see his Kingdom come? Let us light the fire of this passion in the people we see today, this week, and this month. (*Quoted from IHS Global, April Prayer*).

Nurses, doctors, chaplains and all healthcare workers are welcome. Free event, donations welcome.

Contact Georgie at **ncfa.salineprocess@protonmail.com** or mob: 0406 229 583

Saline Taster Blended

NEWCASTLE – FACE-TO-FACE AND ZOOM

FRIDAY 6 AUG 2021

Lambton Tea Rooms, Elder Street
Time: 11:00-12:30pm (organised by NCFA)

Saline Process Witness Training

NEWCASTLE – FACE-TO-FACE

SATURDAY 23 OCT 2021

Newcastle Eye Hospital, 182 Christo Rd, Waratah
Time: 8.30am to 5pm

Saline Process Witness Training

SUMMER HILL, SYDNEY – FACE-TO-FACE AND ZOOM

SATURDAY 6 & 13 NOV 2021

Summer Hill Anglican Church
Time: TBC (organised by CMDFA)

IHS GLOBAL

Christian Medical and Dental Fellowship of Australia

Nurses Christian Fellowship International

Dr Hayley Thomas
Hayley is a GP working in Brisbane, with a research interest in whole person general practice care.

Talking about Death

"None of us, in our culture of comfort, know how to prepare ourselves for dying, but that's what we should do every day. Every single day, we die a thousand deaths."
(Joni Eareckson Tada)[1]

As health professionals, we have the privilege of walking alongside our patients through many of life's greatest joys and challenges. One of the most significant of those challenges is facing the prospect of approaching death.

This can be a difficult topic to address. Conversations with patients about impending death often do not occur until very close to the end-of-life, particularly for non-cancer trajectories such as chronic disease and frailty.[2] Yet, early discussions can be beneficial, improving mood and quality of life, allowing patients to prepare for death, and avoiding inappropriately aggressive medical interventions.[3] Best practice palliative care recognises that preparation for death may involve not only advance healthcare and legal planning, but also the opportunity for emotional and spiritual preparation.[4] As Christians, we may be particularly conscious of the value of this process.

So, why might conversations about approaching death not occur and is there a way forward?

These questions have been explored in general practice qualitative research.[5,6] General practitioners (GPs) in this research recognised that they may be particularly well-placed to initiate conversations about end-of-life with patients, as GPs provide care across the life course, and often have long-standing relationships with patients within their life and community contexts. This entails a professional responsibility to broach discussions about end-of-life when appropriate.

Yet, several factors can result in caution to initiate these discussions.[6] These include professional factors such as prognostic uncertainty, inexperience (for junior practitioners) and unclear role delineation where other GPs or specialists were providing care. There may also be concerns about patients' openness to end-of-life discussions and the potential emotional impact of these conversations upon patients. Conflict within patients' families could also make initiating end-of-life conversations difficult, as could societal and cultural taboos. Additionally, some GPs identified that personal factors, such as a self-perceived imperative to cure and reluctance to confront our own mortality may make some doctors reluctant to initiate end-of-life discussions.

> ***"GPs ... recognised that they may be particularly well-placed to initiate conversations about end-of-life with patients ..."***

As Christians, we are perhaps particularly well-equipped to broach the topic of approaching death with patients, as we have an underlying framework to process and find hope in the face of our own mortality. And perhaps doing so is the first step in preparing ourselves to confidently and sensitively broach the topic of end-of-life with those who are approaching this season.

Additionally, GPs have described their practical approaches to initiating and

engaging in end-of-life discussions.[5] They "prepare the ground" for the discussion by cultivating a strong and trusting doctor-patient relationship and gauging patients' readiness to engage in the conversation through their verbal and non-verbal cues. This provides the relational basis to broach this sensitive topic. However, GPs acknowledged that in some cases the discussion did need to occur without a longstanding pre-existing relationship; this was experienced as being more challenging.

To initiate these conversations, it is necessary to find an entry point.[5] Sometimes, the patient raises the topic and makes this easy. However, even when patients are aware of approaching end of life and would like to discuss it, they may not always initiate this conversation.[7] In these situations, GPs described other ways of broaching these discussions.[5] This could include routinely incorporating discussions about end-of-life planning into specific healthcare encounters (such as health assessments). Sometimes, it could involve directly initiating discussions about poor prognosis. However, GPs also described less direct approaches of planting and 'fertilising the seed' across multiple consultations until the patient was ready to engage. This might, for example, involve flagging the topic for future discussion or enquiring about patients' own views on death or religiosity.

GPs often involve patients' families in end-of-life conversations, with the patient's consent.[5] They describe a variety of communication styles when engaging in these conversations. Some took a very direct approach ('you call a spade a spade'). Several others, however, were more gentle and described 'tiptoeing' around the topic, employing active listening and framing the conversation positively. These approaches could also be combined in a 'gentle but frank' communication style. The approach to communication used seemed to be informed by and tailored to patient and GPs' personalities.

On reflection, several underlying principles of this approach to initiating

"Communicating genuine care in the context of patients' and doctors' unique individuality may be more important than employing any one specific approach to communication."

end-of-life discussions align well with Christ's teaching. Establishing a trusting relationship, within which honest communication can occur about a challenging topic for patients' benefit, may reflect a practical outworking of 'speaking the truth in love' (Eph 4:15). There is also a degree of wisdom involved in considering the timing of these discussions in the context of patients' readiness. And the variety of communication styles described in some ways reminds me of the diversity of ways that Jesus communicated with those he interacted with. With some he was gentle, with others very direct, each appropriate to their needs. It may well be that communicating genuine care in the context of patients' and doctors' unique individuality may be more important than employing any one specific approach to communication.

Initiating end-of-life conversations may never become consistently easy. And despite learning useful principles, we may never develop a simple strategy to broach these discussions that works for everyone. But perhaps that's the way it's meant to be. Personally, this challenges me to become more conscious of when it may serve my patients to sensitively broach these issues, and not to avoid doing so. And may we all continue to grow in and intertwine knowledge, wisdom and love as we tread on this ground.

References

1. Taylor J. An Interview with Joni on Suffering and Healing. 2010. https://www.thegospelcoalition.org/blogs/justin-taylor/an-interview-with-joni-on-suffering-and-healing/. (Accessed 18 March 2021).
2. Abarshi E, Echteld M, Donker G, et al. Discussing end-of-life issues in the last months of life: a nationwide study among general practitioners. *J Palliat Med*. 2011;14(3):323-330. doi: 10.1089/jpm.2010.0312.
3. Wright AA, Zhang B, Ray A, et al. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. *JAMA*. 2008;300(14):1665-1673. doi: 10.1001/jama.300.14.1665.
4. Palliative Care Australia. National Palliative Care Standards. 5th ed. Canberra: PCA; 2018.
5. Deckx L, Thomas HR, Sieben NA, et al. General practitioners' practical approach to initiating end-of-life conversations: a qualitative study. *Fam Pract*. 2020;37(3):401-405. doi: 10.1093/fampra/cmz074.
6. Thomas HR, Deckx L, Sieben NA, et al. General practitioners' considerations when deciding whether to initiate end-of-life conversations: a qualitative study. Fam Pract. 2020;37(4):554-560. doi: 10.1093/fampra/cmz088.
7. Heffner JE, Barbieri C. End-of-life care preferences of patients enrolled in cardiovascular rehabilitation programs. Chest. 2000;117(5):1474-1481. doi: 10.1378/chest.117.5.1474.

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Catherine is a part-time GP in Newcastle. She loves cradle-to-grave medicine, whole-person healthcare and gentle camaraderie with her patients.

Walking Alongside ... Until the Very End

General Practice Care Approaching the End-of-Life

In late 2019, I was inspired to read Atul Gawande's *Being Mortal*[1] after reading a book review in *Luke's Journal, Laughter: The best medicine. Vol 24. No 2. 2019*.[2]

It is one of the few books that has caused me to laugh out loud when sharing passages with whoever happens to be around to listen – quite unexpected when considering the subject matter! Nevertheless, it became the springboard for many conversations about end of life with my patient population.

I have been in my current General Practice for 26 years. The patients who started with me back then are now in their 70s, 80s and 90s. We know each other well. I was really challenged when one 93-year-old patient (who had been admitted to hospital with chest pain twice in the preceding month) said she didn't want to keep getting taken to hospital with heart issues, she just wanted to be kept comfortable and die at home. It took a bit of juggling to figure out how to help her do that whilst still giving her comfort and care at the end of life. Along the way, I learnt about ACAT (Aged Care Assessment Team) referrals, frailty, advanced care directives, ambulance plans and palliative care. These subjects had hitherto been almost unknown in my practice. However, I now initiate conversations in these areas as part of whole-of-life care.

Age is just a number. We all have patients in their nineties who are fighting fit and others in their sixties who are really struggling with their health. What triggers me to start 'end of life' discussions with people is the beginning of their health deterioration, in particular, their frailty. There are a number of frailty scales, but there are some giveaways: patients start falling, they are unable to care for themselves independently, their cognition deteriorates. Formal frailty scores[3] include indicators such as: weakness, fatigue, weight loss, low physical activity, poor balance, low gait speed, visual impairment and cognitive impairment. When some of these factors become evident in a patient's life, I start asking deeper questions in planning for their future.

In the past, patients used to travel along quite well, and then they would have a heart attack, or fall, or cancer, and die within a relatively short time-frame (Trajectory 1 - See Figure 1 below[4]).

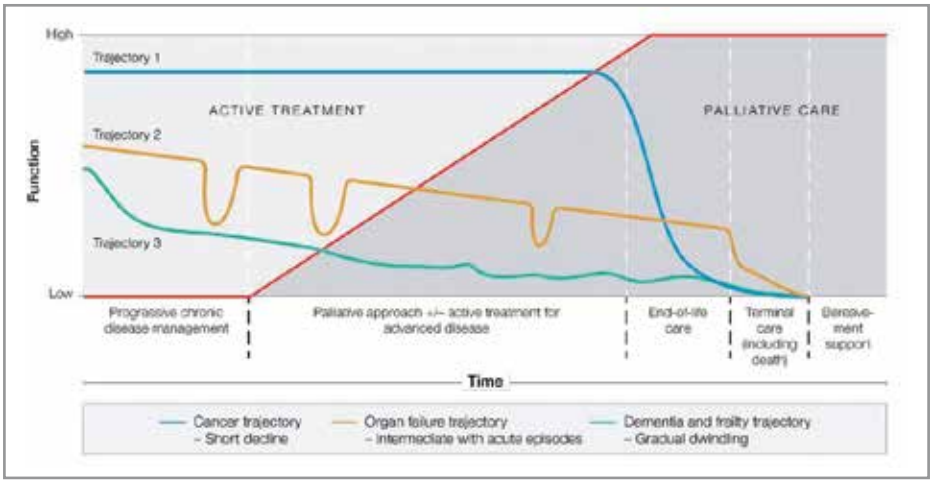

Figure 1

Nowadays, they may still have those big events… but often we save them - a little worse off than previously, but they can keep going until the next event … and we save them, and so on (Trajectory 2 - Figure 1[4]). So, instead of a sudden event leading to an imminent death, the end of life is a slow stepped decline of gradual organ failure. A third option is becoming increasingly common - function dwindles away, often ending in dementia (Trajectory 3 - Figure 1[4]). In 2018, dementia was the second leading cause of death in Australia, accounting for almost 14,000 deaths (ABS 2019[5]). For women, dementia was the leading cause of death (nearly 9000 deaths), while it was the third leading cause for men (nearly 5000 deaths). In 2018, an estimated 376,000 people in Australia had dementia. It is estimated that by 2030, this will increase to around 550,000 (Figure 2[6]). We need to be having these discussions before decline precludes capacity.

It is at the first fall/heart attack/stroke/cancer diagnosis that it makes sense to start these discussions – the event giving a natural focus to consider the "what ifs…?". The 75-year-old health assessment is also an opportunity to discuss advanced care directives for the increasing number of those who are otherwise healthy at this age. No one likes thinking about death, even though we all know that it's inevitable. It is easy to keep putting it off, thinking that we will always have more time – until it is too late. Giving patients an advanced care directive form[7] to fill out and discuss with their loved ones is often a matter-of-fact way to start having discussions around this topic. Personally, I make a note of when I have given a patient a form, and 3 months later raise the topic monthly (if appropriate) to try and get some discussion happening around this rather macabre subject. It is less distressing for everyone to have these conversations at a hypothetical 'arms-length' than when in the middle of a crisis.

Advanced care directives (ACDs) differ, but usually include basics such as next of kin, enduring guardianship, power of attorney details and questions about what is acceptable or not at the end of life. Questions include:

1. Do you want to be resuscitated if your heart stops?
2. Do you want aggressive treatments such as intubation and mechanical ventilation?
3. Do you want antibiotics? Oral at home, or IV in hospital?
4. Do you want tube or intravenous feeding if you can't eat on your own?
5. If you are unable to speak for yourself, who would you like to speak for you?
6. Have you discussed these things with that person?

When patients bring in ACD paperwork, it is an opportunity to chat with them about their thoughts and plans, and to clarify questions or discuss fears. More importantly, it gives family, friends or neighbours (who are more likely to be present when an event occurs) knowledge of the patient's wishes in order to advocate on their behalf at the time. Often there is a chance to reiterate that dying is a natural process and part of life, and to consider whether death at home surrounded by loved ones is preferable to death in a hospital surrounded by machines. Many would rather not push for 'prolonging life, whatever the cost'. This can be a great relief to relatives who might otherwise feel guilty for refusing medical treatment, or withdrawing life-prolonging interventions. Annual review of ACDs helps to accommodate changing circumstances and gives an opportunity to update legal details (such as appointing the enduring guardianship and power of attorney) as well.

Discussion involving the four pillars of bio-psycho-socio-spiritual health can be particularly helpful. Using the illustration of health being like a table with four sturdy legs, it is easy to see that when the biological leg is weakening, it is important to reinforce the other three to keep the table stable. Treating depression and anxiety, improving social connectedness (both in person and using technology – fast-tracked by COVID-19!), and considering spiritual meaning and purpose all contribute to a greater sense of well-being, even as the body fails. Organising ACAT involvement to minimise time and energy spent on activities of daily living (ADLs) and to maximise time spent in enjoyable pursuits is often helpful. Patients are

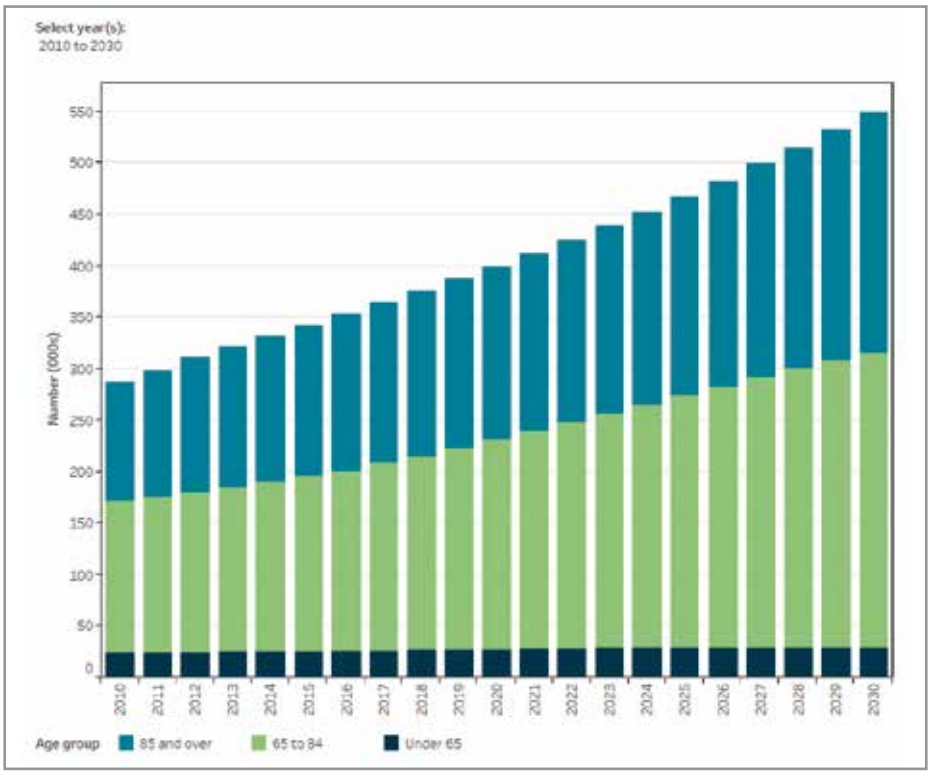

Figure 2

invariably keen to prevent falls and delay dementia if they know that this contributes to better quality of life. Falls Prevention clinics, over-55 exercise classes, line-dancing, tai chi, ukulele groups or language learning often provide multiple benefits – fun, social interactions, improved balance and reflexes, and instilling a sense of meaning and dignity. It is well worth investing time and effort into incorporating all four pillars into everyday consultation. Courses such as PRIME[8] and Saline Process[9] are particularly helpful in establishing comfortable spiritual history-taking and opening patients to consider that aspect of life. CMDFA has substantial links with both.[10,11]

Once a specific event or diagnosis has been made, discussion about end-of-life care may not be possible in general practice. The hospital is often the setting for major organ failure or cancer care. If it looks like cancer or other catastrophic organ failure is a possibility, a GP may be able to give the patient the option of returning for further conversations even if the majority of future care is in the hands of the hospital or oncology team:

> *"I often don't see a patient much after a diagnosis such as this since the hospital machine takes over, but my door is always open here for you and your family to talk if you would like to do so."*

Atul Gawande[1a] describes the following:

> *[Medical personnel may] focus on laying out the facts and the options… [However, a patient may be] overwhelmed by anxiety – anxiety about death, anxiety about suffering, anxiety about loved ones, anxiety about finances… No one conversation can address them all. Arriving at an acceptance of one's mortality and a clear understanding of the limits and the possibilities of medicine is a process, not an epiphany.*
>
> *There is no single way to take people with terminal illness through the process but there are some rules … You sit down. You make time. You're not determining whether they want treatment X versus Y. You're trying to learn what's most important to them under the circumstances – so that you can provide information and advice that gives them their best chance of achieving it. This process requires as much listening as talking …*
>
> *The words you use matter. You should say, "I wish things were different." You don't ask, "What do you want to do when you are dying?" You ask, "If time becomes short, what is most important to you?"*

"Arriving at an acceptance of one's mortality and a clear understanding of the limits and the possibilities of medicine is a process, not an epiphany."

Questions for a general practitioner might include:

1. What do you understand your prognosis to be?
2. What are your concerns about what lies ahead? (fears)
3. What kinds of trade-offs are you willing to make?
4. What do you want to be able to do to make a treatment worthwhile? (hopes)
5. How do you want to spend your time if your health worsens?
6. Who do you want to make decisions if you can't?

It may be helpful to consider whether one's fears or one's hopes should determine what to do. Conversations such as this with a family member present can make a huge difference in making decisions when the time comes. At the end, it is helpful for them to know what the patient views as worth fighting for, and when to surrender if that cannot be achieved. This minimises the hospital default of fighting to the bitter end, making end of life more peaceful and decisions less distressing.

Euthanasia or physician-assisted dying may also be raised. People are often concerned about the process of dying and, unsurprisingly, the idea of falling asleep and not waking up

is attractive. This may be especially so if they themselves have witnessed someone dying with substantial suffering or indignity. If this is the case, it is wise to dedicate a separate consultation to hear the patient's story and to listen to their desires and concerns. Legal requirements regarding physician-assisted dying vary from state to state, and may change in the future. As yet, in NSW, I can state that I do not want to be (nor may I legally be) the one who deliberately provides them with the means of dying. However, I can reiterate that my aim is to keep them comfortable during the dying process, and support their wish to be at home, hospice or hospital. Though assisted living is harder than assisted dying, its possibilities are far greater as well.

To this end, ambulance care plans and the involvement of the local palliative care team is helpful. GPs can write instructions so that when an ambulance is called, the paramedics know whether they are to transfer the patient to hospital, or to keep the patient comfortable at home. Medication options and doses are specified, as well as details of ongoing care and contact numbers. Ambulance care plans can either be written generally,[12] or for palliative care.[13] This second option is more relevant to end-of-life care, but may depend on whether the local palliative care team is willing to accept referrals not involving imminent death, e.g. ischaemic heart disease, heart failure, COAD, renal disease, etc.. Discussion and relationship with your local palliative care team is highly recommended to facilitate a smooth transition at the end of life, especially if a patient would prefer to be cared for at home, rather than transferred to hospital.

I'll leave you with a few more words from Atul Gawande[1b]:

> *…[S]ociety has forgotten what scholars call the 'dying role' and its importance to people as life approaches its end. People want to share memories, pass on wisdom and keepsakes, settle relationships, establish their legacies, make peace with God, and ensure that those who*

are left behind will be okay. They want to end their stories on their own terms. This role is… among life's most important, for both the dying and those left behind. And if it is, the way we deny people this role… is cause for everlasting shame. Over and over, we in medicine inflict deep gouges at the end of people's lives and then stand oblivious to the harm done.

"Discussion and relationship with your local palliative care team is highly recommended to facilitate a smooth transition at the end of life."

…endings matter, not just for the person but, perhaps even more, for the ones left behind[1c]… We've been wrong about what our job is in medicine. We think our job is to ensure health and survival. But really it is larger than that. It is to enable well-being. And well-being is about the reasons one wishes to be alive. Those reasons matter… all along the way.[1d]

Whole-person care throughout life is a great privilege, for GPs in particular. As Christians, we can go further than Gawande - tending to people's well-being beyond death and into eternity as they near the end of this life. Praying for opportunities to offer peace and hope to dying patients and their families underscores our care in these situations. God is at work and we are privileged to share in that work with him.

> *"Though we speak in this way, yet in your case, beloved, we feel sure of better things – things that belong to salvation. For God is not unjust so as to overlook your work and the love that you have shown for his name in serving the saints, as you still do. And we desire each one of you to show the same earnestness to have the full assurance of* ***hope until the end****, so that you may not be sluggish, but imitators of those who through faith and patience inherit the promises."*
> Hebrews 6:9-12

References:

1. Gawande, Atul. Being Mortal: Illness, Medicine and What Matters in the End. Profile Books. 2014. P182-183a, 249b, 252c, 259d.
2. Hoddle, G. *Being Mortal* Book Review. *Luke's Journal.* CMDFA. 2019. Laughter: The best medicine. Vol 24. No 2. p55 https://lukesjournalcmdfa.com/2020/01/09/book-review-being-mortal-georgie-hoddle/
3. Kojima, G; Liljas, A; Iliffe, S. *Frailty syndrome: implications and challenges for health care police*. Risk Manag Healthc Policy. 2019; 12: 23–30. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6385767/
4. Murray SA, Kendall M, Boyd K, Sheikh A. Illness trajectories and palliative care. BMJ 2005;330:1007. [Accessed 14 August 2019 - *RACGP aged care clinical guide (Silver Book)* 5th edition. Dec 2020.] https://www.racgp.org.au/silverbook
5. Australian Bureau of Statistics, 2019. https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/2019
6. Australia's health 2018 (full publication; 18Jun2019 edition) *Australian Institute of Health and Welfare*. 2019, p138. https://www.aihw.gov.au/getmedia/7c42913d-295f-4bc9-9c24-4e44eff4a04a/aihw-aus-221.pdf.aspx?inline=true
7. Austin Health 2021. *Advanced Care Planning Australia*. https://www.advancecareplanning.org.au/create-your-plan
8. https://www.prime-international.org/home.htm
9. https://www.ihsglobal.org/SalineProcess
10. https://www.cmdfa.org.au/saline-process
11. http://healthserve.org.au/programs-of-health-serve-australia/152-prime-medical-education-program
12. Sydney Local Health District, NSW ambulance authorized care plan. https://www.slhd.nsw.gov.au/btf/pdfs/Amb/Authorised_Care_Form.pdf
13. Sydney Local Health District, NSW ambulance palliative care plan. https://www.slhd.nsw.gov.au/btf/pdfs/Amb/GP_Booklet.pdf

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Will it hurt to die?
Thoughtful end of life prescribing

Death and pain are two of the most complex of human experiences and can be examined from theological, philosophical, sociological, ethical and medical perspectives. Revelation speaks of a time when there will be no more death or pain which we look forward to with faith, hope and confidence.

> *"And I heard a loud voice from the throne saying, "Look! God's dwelling place is now among the people, and He will dwell with them. They will be His people, and God Himself will be with them and be their God. He will wipe every tear from their eyes. There will be no more death or mourning or crying or pain, for the old order of things has passed away."*
> (Revelation 21:3-4)

In the meantime, we as doctors have the awesome responsibility of caring for people as they die, mourn, cry and suffer pain.

This article focuses on pain in the last days of life from a medical perspective.

One of the challenges of palliative care is identifying when a person is in the last days of life. The Australian Commission on Safety and Quality in Health Care[1] identifies the following triggers:

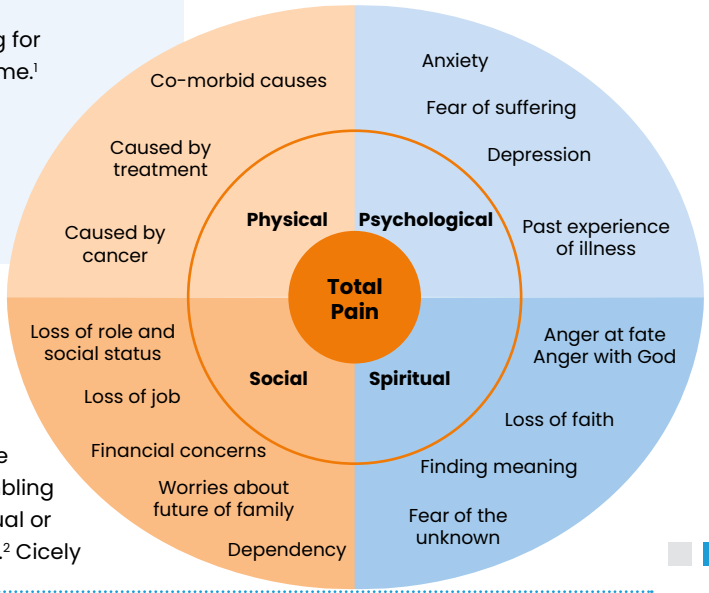
- Ongoing deterioration despite optimal clinical care
- Increasing difficulty swallowing or taking oral medications
- Increasing disinterest in food or fluid
- Profound weakness, decrease in function and being bed bound
- Drowsiness or sleeping for extended periods of time.[1]

If someone is in their last days of life, their goals of care need to be clear to everyone involved.

What is pain?

The International Association for the Study of Pain defines pain as "An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage".[2] Cicely Saunders coined the term Total Pain in 1978 to describe the suffering associated with physical, psychological, social and spiritual distress.[2] Death and dying, due to the grief of loss and separation from those we love, the physical illness and fear, is almost always associated with pain under Saunders' definition, not only for the person dying but also for their family and friends.

We understand more how the psychological, spiritual and social aspects interact with the experience of



pain, modulating pain to either increase or decrease the pain.[2]

What is the prevalence of pain at the end of life?

Pain is common at the end of life. Whatever the cause of severe illness, more than half of people (52.4%) will experience pain in the last two weeks of life.[3] In an Australian sample of 18,975 patients receiving palliative care and entering the terminal phase 52.7% of patients were pain free, 6% had severe pain (7-10/10 on a Numeric Rating Scale [NRS]) and the remainder had mild to moderate pain.[3] It is therefore important to identify who in your care may be at risk of dying (see blue box, p32) and screen them regularly to see if they have pain. For people who are cognitively intact and able to verbalise their pain, this can be done using a NRS or a categorical scale (none, mild, moderate or severe.) For those with cognitive impairment, this can be done with a tool developed specifically for that population such as the Abbey Pain Scale.

What is important to people nearing the end of life?

Asking people what is important to them as they near the end of life will help shed light on ways we can best help. In an American cohort, nine items were determined from previous focus groups and ranked in order of importance. The two most important were to be pain free and to be at peace with God. Other factors ranked as important by more than 70% of respondents were to be free of other symptoms, being prepared for death, having a sense of completion and being treated as a whole person.[3]

Screening for pain and assessing pain at the end of life

People nearing the end of life will need regular assessment to detect uncontrolled pain. For people with pain, a comprehensive assessment will help reveal the cause and the mechanism of pain, whether nociceptive or neuropathic and any modulators of the pain. This includes a history of the pain experience including: Precipitating and relieving factors, Quality of pain and quality of life (impact of the pain), Radiation, Site and Timing (PQRST) of the pain. It is also important to understand what the pain means to the person. For example, in someone with cancer that has spread to the bones, do they fear that the pain signals they are becoming quadriplegic, or that it may be a precursor to an impending fracture or that may be transferred to a hospital for acute care? The pain may be exacerbated by fear and other causes of distress such as anxiety, depression or associated symptoms (such as constipation) which may occur with pain. People may be afraid of worsening and persisting pain, disability and, importantly, afraid of dying and death.

"Asking people what is important to them as they near the end of life will help shed light on ways we can best help."

Managing pain at the end of life

Managing pain at the end of life is ideally done by a multidisciplinary team. As we have seen, spiritual, psychological and social distress can all exacerbate pain. This distress does not respond well to pharmacological treatment. Pastoral care, good communication, ensuring people are dying in their preferred place, making sure the person dying has the opportunity to connect with all the people who they love, all help to relieve suffering.

Surprisingly, there have been very few studies of opioids at the end of life. Morphine and fentanyl have been found to be effective although more studies are needed.[3]

Safe anticipatory prescribing in case pain develops

A significant proportion of patients will develop pain in the last days of life. Since one of the highest priorities for people at the end of life is being pain free, guidelines recommend anticipatory prescribing to ensure analgesia is available if needed.

Prior to prescribing anticipatory medications, discuss the plan with the patient and family/person responsible. Review the current medications and check for potential interactions, allergies and contraindications. Consider stopping medications which are no longer contributing to the person's quality of life. Once prescribed, hand over to medical and nursing staff involved in caring for the patient. The patient should be monitored closely for symptoms.

If pain is identified, **non-pharmacological approaches** should be tried first such as repositioning and excluding urinary retention. For opioid naïve people, morphine 2.5mg subcutaneously one hourly as required is an appropriate starting dose, with a maximum of 6 doses or 15mg in 24 hours. It is better not to put a dose range, but be specific about the amount and frequency. For people with an eGFR<30, consider referral to a specialist palliative care service.

For those already on opioids, the regular dose will need to be converted to a parenteral dose. Guidance for dose conversions is available on the Australian and New Zealand College of Anaesthetists Opioid Calculator app. The required PRN dose will be one sixth of the total 24 hour opioid dose given subcutaneously one hourly PRN.

Response to analgesia must be closely monitored to ensure appropriate dosing to relieve pain without adverse effects. It is important to note that HYDROmorphone is FIVE times more potent than morphine. If you are considering its use, please consult your local specialist palliative care service.[3]

It hurts the doctor too

We have thought about the pain and grief suffered by the dying and their family and friends. We all know the grief and pain we, as doctors, experience when people we have cared for, sometimes for decades, die. We have a responsibility to care for ourselves and to seek support if we are distressed. Christ is our strength, our source of love, light, life, joy, peace and comfort. His grace is sufficient. He provides for all our needs and that provision includes those who can comfort us and provide wise counsel.

References:

1. Australian Commission on Safety and Quality in Healthcare. 2021. Available from https://www.safetyandquality.gov.au/sites/default/files/2020-11/end-of-life_care_-_last_days_of_life_0.pdf.)
2. Raja SN, Carr DB, Cohen M, Finnerup NB, Flor H, Gibson S, Keefe FJ, Mogil JS, Ringkamp M, Sluka KA, Song, X-J, Stevens, Bonnie Sullivan, Mark D. Tutelman, Perri R. Ushida, Takahiro Vader, Kyle The revised International Association for the Study of Pain definition of pain: concepts, challenges, and compromises, *PAIN*. 2020;161(9):1976-1982. Available from https://doi: 10.1097/j.pain.0000000000001939
3. Saunders CM, The management of terminal malignant disease. 1st Ed. London: Edward Arnold, 1978.
4. Siddall.PJ, Lovell M, MacLeod R. Spirituality: What is its role in pain medicine? *Pain Medicine*, 2015.16(1)51–60. Available from, https://doi.org/10.1111/pme.12511
5. Kehl KA, Kowalkowski JA. A systematic review of the prevalence of signs of impending death and symptoms in the last 2 weeks of life. *Am. J.* Hospice Pall. Med. 2013;30(6):601-616. Available from https:// doi:10.1177/1049909112468222
6. Clark K. Care at the very end-of-life: Dying cancer patients and their chosen family's needs. *Cancers (Basel)* 2017.9(2):11. Available from https//doi:10.3390/cancers9020011
7. Steinhauser KE, Christakis NA, Clipp EC, McNeilly M, McIntyre L, Tulsky JA. Factors considered Important at the end of life by patients, family, physicians, and other care providers. *JAMA*. 2000;284(19):2476–2482. Available from https:// doi:10.1001/jama.284.19.2476
8. Jansen K, Haugen DF, Pont L, Ruths S. Safety and effectiveness of palliative drug treatment in the last days of life. -A systematic literature review. *J Pain Symptom Manage*. 2018 Feb;55(2):508-521. e3. Availabke from https:// doi: 10.1016/j.jpainsymman.2017.06.010. Epub 2017 Aug 10. PMID: 28803078.
9. *Clinical Excellence Commission Last Days of Life Toolkit* 2017 Sydney Clinical Excellence Commission.

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Managing the Dying: The Gospel, Spirituality or Both?

Those who are dying have complex needs. They may require considerations of physical (especially pain and other symptoms), psychological, social, cultural and spiritual factors.

The vulnerability and the power differential between the clinician and the patient also need to be considered. Initial information obtained from the patient is better done through a narrative process where the patient leads the conversation rather than a systematic interrogation where the doctor leads.

In our community, relatively few patients these days would identify as Christian. Therefore, direct discussion of how Christianity may be of benefit to them may not be relevant. Where the patient expresses a faith during discussion, the Christian clinician may want to directly discuss the matter or ask for a chaplain or religious person of their persuasion to be available if the patient has specifically religious questions.

It is important that matters of faith or spirituality are brought up in the initial conversation, if possible, as this will indicate to the patient that these are important in their management. If the clinician works as part of the team, it is important that multiple members don't ask the same questions of the patient as it seems that patients do not want to repeatedly answer the same questions. One patient in our unit said, "Do I have to provide this information repeatedly, don't you people talk to each other?"

Some clinicians feel that discussions of faith or spirituality should be kept as a private matter and nothing should be written in the patient records about spiritual symptoms. If the patient feels that it should be kept private then that should be done, but otherwise it is important that each clinician is aware about the patients concerns relating to faith and spirituality in the same way they would be made aware of physical symptoms.

Religion

Religion is a system of beliefs and practises associated with an individual or community which transcends physical life and may relate to a deity. Christian faith is defined in Hebrews 11:1, *"Now faith is the confidence in what we hope for and assurance about what we do not see"*. For people of Christian faith, answers can be provided to many significant spiritual stressors about life.

Spirituality

It is not uncommon to hear people say these days, "I am spiritual, but not

Some Spiritual Stressors*	Some Biblical answers*
Loss of Dignity	Made in the image of God (Gen 1:27)
Fear	No fear (Psalm 23:4)
Hopelessness	Hope (Rom 15:13)
Being Unloved	Love of the Father (1 Jn 3:1)
No Peace	My peace I give to you (Jn 14:27)
Anxiety relating to death	Death defeated (1 Cor 15)
Unforgiveness	Forgive one another (Col 3:13; 1 John 1:9)
Is there life after death?	Eternal life (John 10:28; John 14:1,2)

*These are just some examples, there are many others.

religious". Let us explore the two terms to try to unravel what they mean in a clinical context, remembering that it is impossible to define spirituality in general.

The National Church Life Survey quotes, "The term 'spirituality' is French Catholic in origin and did not fully develop as a concept until the 18th Century. Giving an exact definition for the term becomes difficult. Used by the Church at many stages and in varying ways to attempt to define, explain, and outline the entire relationship between a person and God, a precise definition becomes impossible. Contemporary usage in wider society complicates a definition further with the concept leaving its Christian roots behind and coming to mean any aspect of humanity's connection to something other than itself. This includes deism (natural revelation), and theism (revealed revelation), yet also expands to include even other human relationships. Spirituality in its broadest sense is the evidence of, or attempt to explain, human transcendence."[1]

The twin cultural trends of deinstitutionalisation and individualism have, for many, moved spiritual practice away from the public rituals of institutional Christianity to the private experience of God within. Once synonymous, 'religious' and 'spiritual' have now come to describe seemingly distinct (but sometimes overlapping) domains of human activity.

Roxanne Stone, editor-in-chief at Barna Group, a Christian survey group from California, commenting on spirituality in their sample of American people, divided those who described their spirituality into two groups. "The first is disenchanted with the church; the second is disenchanted with religion. The former still hold tightly to Christian belief, they just do not find value in the church as a component of that belief. The latter have primarily rejected religion and prefer instead to define their own boundaries for spirituality — often mixing beliefs and practices from a variety of religions and traditions". A detailed analysis of these groups is well worth reading.[2]

Spirituality as part of illness symptomatology

Spiritual issues have been noted for centuries among patients suffering illness and has been commented on, for example, by Hippocrates. Cecily Saunders, the founder of the modern hospice movement, emphasised spiritual care as part of the holistic care that needs to be given to palliative care patients.[3]

> ***"People who have a terminal illness tend to review their lives looking for episodes that have made them thankful or regretful."***

Research aimed at relating spirituality symptoms to outcomes stimulated the search for definitions that could be applied to these studies. For example, Christina Puchalski, MD, Director of the George Washington Institute for Spirituality and Health, contends that, "spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred."[4] Spirituality is deemed applicable to all people, but is especially evident in those facing a crisis such as a terminal illness.

There has been consensus building in applying a definition to spirituality in palliative care. In 2013, the International Consensus Conference defined spirituality as,

> *"the dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose and transcendence and experience relationship to self, family, others, community, society, nature and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices."*[5]

People who have a terminal illness tend to review their lives looking for episodes that have made them thankful or regretful. Since dying includes a series of losses, people often become distressed by regretful memories. Surveys in the United States of palliative care patients have shown that most people wish to discuss their spiritual symptoms with their clinician, but other studies show that less than 50% of doctors believe it is their role to address such concerns.[6,7] The result is that many people who are dying are denied from discussing their spiritual distress with their clinicians.

Some of the ways patients express their spiritual distress when they are facing a terminal illness may include a desire for peace, anger or resentment, guilt, sadness or grief, lack of meaning in their life, loss of hope or purpose, feeling life or God has treated them unfairly, fear of death, lack of dignity, loss of role in family or community, or both, unresolved religious concerns or spiritual questions, doubt, helplessness, loss of self-worth, loss of control, failure of reconciliation, loss of connection with people or place and many more. These items of distress may be expressed directly or indirectly. Sometimes, skill is required to untangle symptoms that are attributed directly to common items such as the standard of food or medical attention that are really proxies for spiritual distress due to deeper causes.

Many practitioners do not remember or have not been taught how to include spirituality questions in the discussion of the patient's illness. There are several ways to begin if patients do not mention them in initial narratives. One is the HOPE questionnaire.[8] "H" covers sources of hope, meaning, strength, peace, and love. "O" covers inquiry about organised religion. "P" explores personal spirituality and practices. "E" explores the effects of care and end of life decisions. Other ways of including spirituality discussions are listed by Balboni et al.[9]

Caring for the patient

Spiritual symptoms do not remain static, but often vary with the patient's clinical status. Discussion is best introduced at the first meeting, but follow-up assessments will be required.

The nurse or pastoral care practitioner often participates, but the patient often expects the doctor to be involved as that person is involved in managing other symptoms. Patients need to know that clinicians are interested in their spiritual lives and the distress that may arise at times of crisis.

I remember well a patient who had severe abdominal pain. She complained about it as her sole symptom which we were able to completely relieve. After a couple of days, she stated that she had other worries regarding her family and her remaining life. The physical pain had masked the spiritual pain. She said she would rather have the pain back than to contend with the disturbing spiritual issues that had arisen.

How can spirituality and the Gospel be best presented to the palliative care patient?

For the clinician, coping with spiritual distress can be difficult and distressing. There is no "magic bullet" or wonder drug for this condition. It involves clinicians not "distancing" themselves from the patient, but skilfully and empathetically listening to the distress and allowing the patient to work through it themselves. Holistic care should be the aim of care for all palliative care patients whether they are managed in general practice, specialist practice, in hospitals or nursing homes. Studies have also shown excellent results in other units, such as intensive care units who focus on spiritual symptoms.[10]

> ***"Patients need to know that clinicians are interested in their spiritual lives and the distress that may arise at times of crisis."***

Christian health care professionals who wish to share their Christian faith might well consider beginning with a spirituality assessment. Exploring spirituality with the patient has proven benefits for patients who are facing a health crisis and allows Christian health care professionals to discuss their Christian beliefs if the patient is interested in Christian answers to these major spiritual issues. Beginning with a spiritual assessment also allows the Christian health care professional to provide spiritual care to all patients, religious or not, which should be the goal of palliative care in all modes of medical care.

References

1. National Church Life Survey quoted in http://www.ncls.org.au/default.aspx?sitemapid=26.
2. Roxanne Stone quoted in https://www.barna.com/research/meet-spiritual-not-religious/
3. Saunders C. Spiritual Pain. J. Palliat Care 1988;4:29-32
4. Pulchalski CM et al. J Palliat Med 2014; 17:642-656.
5. Pulchalski CM et al. J Palliat Med 2014; 17:642-656.
6. El Nawawi MN et al. Curr Opin Support Palliat Care 2012;6:269-274
7. Rodin D et al. Support Care Cancer 2015;23:2543-2550
8. Anandarajah, G., & Hight, E. (2001). Spirituality and medical practice: using the HOPE questions as a practical tool for spiritual assessment. *American family physician*, 63(1), 81.
9. Balboni TA et al. J Pain and Symptom Management 2017:54;441-453
10. Swinton M et al. Amer J Resp and Critical Medicine 2017;195:198-204.

A Personal Perspective of Experiencing Grief in Lockdown

by Jo Patterson, *continued from page 23*

During this time Mum told me she'd had enough and wanted to go. In her own expression of faith she told me where she was going – the "Pearly Gates" beckoned her. Then at the end of this long day she slipped away quietly without anyone with her, which was just like her. Always independent and not wanting a fuss made of her. So we mourned for our loss and her gain.

The funeral was delayed as you would expect due to the high demand for their services. But we were finally able to have a service with all immediate family members present. A chance to gather and mourn after months of stress and uncertainty. It was a moment when together we felt relief, a finalising of the crisis and a time to share memories.

Our flight back to Australia was booked for shortly after the funeral, but as you may have anticipated already, getting back to Australia was not an easy process. We were distressed to be bumped off the first flight at the end of June but didn't anticipate being bumped a further 3 times. We finally secured a flight in September after applying to the NSW government for medical exemption, to return for a family member back in Australia. Otherwise, we could possibly still be there, a year on!

The extra time with our family, though unexpected, was a time to process together. We stayed with my Dad in the first months of adjusting and we grieved together. Later on we took advantage of the beautiful English summer to visit other family and friends in the Lake District and Peak District. Another chance to slow down, to process Mum's rapid death and make sense of the emotional upheaval that was part of 2020.

Reflecting on the months that have just passed make me realise I can't hold onto my disappointments and regrets. I have been given a chance to show grace and forgiveness towards my Mum, as Jesus had already shown for me. I feel God's mercy in allowing us some final precious weeks in a better place with her than we had ever experienced. COVID may have disrupted our lives but it gave me the space and the opportunity to heal.

Dr Bo Wong
Bo was born in Malaysia and is married to Lay. He has a daughter, Joyce (who is married to Jeram), and a son, Joel. Bo completed an MBBS at the University of Sydney (1997). He works as a GP in Mayfield, Newcastle, and serves as an Elder at Grace Evangelical Church Newcastle.

Quality of Life: *Psyche* or *Zoe*?

The decision to treat or to palliate a patient with a life-threatening condition is often dependent on the expected quality of life after treatment.

> *"Quality of life" is defined by the World Health Organisation as "an individual's perception of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns."*

Everything we do to patients is done with the hope of improving, or at least maintaining, their quality of life. We try to reduce pain, maintain function and promote mental well-being. However, quality of life is a perception related to a person's expectations in life. Regardless of how much we do for patients, if their expectations exceed what we can do, they may still be unhappy with the treatment they receive.

One of the questions patients frequently ask is, "Why do I have arthritis (or another condition) now? I have never had it before." Such a question implies their expectation to remain in good health forever. They often seem surprised that their health is deteriorating. The more severe the defects are, the harder it may be for people to accept. Our desired quality of life may be unrealistic regardless of what condition we are in.

Sometimes I wonder how Adam and Eve would have considered their quality of life. They lived in a world without sickness or death, with everything they needed provided for them. However, they still had a feeling that something was lacking. They knew that they were not exactly like God. They wanted to improve themselves. They thought that they could be more like God when they were 'mature' enough to decide for themselves to eat the fruit which God forbade them to eat. However, being independent from God did not make them more like God. Instead, it made them more like the devil. For the sake of being independent, they chose to ignore good advice and follow bad. They would have been more like God by obeying God, rather than disobeying him.

"Our desired quality of life may be unrealistic regardless of what condition we are in."

We live in the same culture. We base our expectations of life on our experience and passions. We still want to decide what we want in life independently. We may listen to advice, but we tend to accept only opinions which agree with our hearts. It is therefore difficult to improve a patient's quality of life without first addressing his/her heart.

Over the past few months, I have started trying patients on medicinal cannabis for chronic pain and anxiety. For me to prescribe such medications under the Special Access Scheme, I need to do a quality-of-life assessment every month for each patient. When I compare patients' scores for their quality of life, I am often disappointed that though medicinal cannabis does seem to relieve pain and anxiety, there has not been much improvement in their quality of life scores (which mostly stay around 3/10). Patients often have new problems they wish to have resolved when pain or anxiety have settled.

It appears that we are created with a life which is not complete in itself.

Even Adam and Eve were looking for something greater. We are created with a life that seeks something greater, and this something is not creatable, it can only be reached by being intimate with the Giver of life. There are two types of life: one we are born with, the other we get by being intimate with God.

In John 12:25, Jesus said, *"Whoever loves his life loses it, and whoever hates his life in this world will keep it for eternal life."* In Greek, Jesus' statement was expressed as *"Whoever loves his* Psyche *loses it, and whoever hates his* Psyche *in the world will keep (it for)* Zoe*."* In this statement, Jesus was contrasting two types of life – *Psyche* and *Zoe*. In the Bible, *Psyche* is often translated as '*soul*' in English. It is sometimes translated as '*life*' as in John 12:25. *Zoe* is often translated as *eternal life*, it is sometimes translated as '*life*', as in John 1:4 (In him was *life*, and the *life* was the light of men).

Psyche is life as we know it. However, Jesus knew more than *Psyche*, as he also had *Zoe* (*"And the Word became flesh, and dwelt among us…"* John 1:14). *Psyche* is life that comes with a perishable body. *Zoe* is life that will inherit an imperishable body. (In His resurrection, Jesus was the first to inherit the imperishable body). Both *Psyche* and *Zoe* struggle with the perishable body. *Psyche* struggles to keep the perishable body going forever. *Zoe* struggles to keep the perishable body under control.

> ***"Psyche is often translated as 'soul' / 'life'. Zoe is often translated as 'eternal life' / 'life'."***

When we have only *Psyche*, we will try our best to keep our bodies going for as long as possible. We will also keep looking for something better. *Psyche* is designed to thirst for something greater than itself. We will never be satisfied with the quality of our *Psyche*. In John 4:13-14, Jesus said, *"Everyone who drinks of this water will be thirsty again, but whoever drinks of the water that I give him will never be thirsty again."* Medical interventions and counselling may reduce our thirst temporarily, but until we drink the living water from Jesus, our quest for a better quality of life will not end.

Counter-intuitively, *Zoe* is not something we can achieve. It does not come by doing, but by knowing. In John 17:3, Jesus said, *"And this is Zoe, that they know you the only true God, and Jesus Christ whom you have sent."* Life is largely about relationship. *Zoe* comes purely by us knowing and relating to God through Jesus Christ. *Psyche* is also established by how we relate to others. To have a stable *Psyche*, we need to have some sort of anchor. Most patients have poor quality of life not because of physical disability, but due to psychological uncertainty. They do not have someone whom they can trust or depend on. Once again, we see the limited effectiveness of medical and psychological intervention in improving a person's quality of life. These do not solve the problems of love, justice, and forgiveness.

For people who are facing imminent death, having someone present with them is often more important than medication. This is especially so in our individualistic world where people do not value relationships whilst they are healthy. However, most health professionals are too busy to spend much time with patients. This is where patients may benefit from a chaplain, pastoral carer or other personal support. People who have *Zoe* have an anchor in Jesus and therefore have less fear facing the demise of their bodies. People who have only *Psyche* need lots of reassurance and encouragement to go through the valley of the shadow of death. As Christian health professionals, we have the opportunity of offering *Zoe* by our presence, prayer and pastoral care.

Dr Tyler Schofield

Tyler works both with other Christian GPs in a family general practice and also in a highly secular multidisciplinary adolescent mental health clinic. He seeks to be wise, courageous and loving in the way he points disoriented, distressed patients who are dying of thirst to the life-giving spiritual waters of God. He works directly with a local church and refers patients to experience first-hand the love of Christians in the community. Tyler aims to reflect God's hope and invites suffering patients to taste and see that God is truly good.

My Patient Took His Life

Repeatedly and consistently, I pleaded with my patient to persevere. I brought all of my resources and every last bit of my interpersonal capacity to bear. It wasn't enough.

His wife is now widowed and his adolescent children are fatherless.

We met about two years ago, and I cared for him over eight consultations, spanning two short months. My friend, an experienced medical practitioner, had been pastorally caring for him at church and asked me to consider taking over care from his regular GP. From the outset, his clinical situation was complex and hard to traverse. He was recently afflicted by an untreatable disease which had suddenly and utterly taken away his vision. He was no longer able to work, to provide for his family. A deep, melancholic depression set in. From the outset he was sharply offended when I enquired about suicidality. Suicide was unthinkable to him in light of his faith and his love for his family.

He was very difficult to treat as his depression continued to relentlessly deteriorate. As his hopelessness and despair mounted, his willingness and capacity to engage therapeutically diminished. I was increasingly concerned about the very high risk of suicide, but I struggled to access additional help. Because he was uninsured and newly unable to work, he felt very resistant to engage a private hospital for admission. He was categorically unwilling to have a public psychiatric admission. It would not have been possible to have this very intelligent man admitted under the mental health act without the definitive backing of his family for such a decision. As he deteriorated, medications started by me sharply worsened his agitation from the side effect of severe akathisia. I was extremely worried about him, concerned for his life and saw him at least weekly during this sharp deterioration in his depression.

> ***" I was extremely worried about him, concerned for his life and saw him at least weekly during this sharp deterioration in his depression."***

But then the medications began to work. His mood began to lift. For the first time, I started to see his personality emerge, his dark humour, a sense of hope. I started to feel hope too. I recall my last consult with him, it was the first consult where his wife felt he was safe enough to let him attend alone. This patient was amongst a very small group for whom I have appreciated suicide was of grave and almost imminent concern. But increasingly over time and in our last consultation particularly, my own hope started to emerge, "I think that he is going to pull through this".

And then, within days, he took his life.

Losing him was a deep shock. A sorrow-filled blend of disbelief, sympathy and frustration at the squanderous nature of such a death and anger at the abandonment of his family. His death rattled me to the core.

Suicidality in General Practice

In my 14 years of work in General Practice, I have always carried a disproportionate load of suicidal patients. Out of Christ-inspired conviction I've actively sought to take on the care of patients that many colleagues prefer to avoid. This

has meant caring for far more people with complex mental health issues, family and social problems, addictions, homelessness and other difficult situations. It would be very rare for me to have a working day without at least one substantially suicidal patient. As a result, I have developed ways to be there for them, to estimate risk, seek appropriate support, involve the people in their lives and other clinicians. Naturally, I do all that I can in the consult: challenging patients to push back against suicidality, to resist fantasising or dwelling on thoughts of dying and means of dying, to have a clear rebuttal against any reasons to die. I often am quite personal in exhorting patients to carry on and plead with them to carry on for the sake of loved ones. I express a commitment to stay alongside them through the process of recovery until we can look back on suicidality as nothing but a memory.

Despite all of my efforts, I recognise that nothing I can do can keep a person safe. Historically I have had to prayerfully entrust each one of my suicidal patients to the Lord. If my counsel is of any benefit to a person, to persuade them to live, to counter the lies of the Enemy, to be comforting in the midst of a harsh depression, surely it is the Lord working through my words by the wisdom He has provided. At the end of the day I never remain with my patients, they are in God's hands. I'm not omniscient or omnipotent, but God is. God numbers our days, and I am reminded that not a single sparrow falls to the ground without the sovereign control of the Lord (Matt 10:29). Thus far in General Practice, God has responded to my meagre trust in Him by enabling me to not be ridden with anxiety for each of my profoundly worrying patients.

And yet, this patient's death was really hard to reconcile. So many of my most dangerously suicidal patients are young and impulsive, misusing alcohol and drugs, separated from family and socially isolated with either highly abusive friendships or none at all. But this patient was different. Of all the suicidal patients I can recall caring for he had the most support. He had a loving and highly involved wife, dependant but

connected adolescent kids, a good circle of committed friends, a lovingly involved and pastorally geared church with regular support from his pastor, his medical church friend and numerous other people in his church family. He expressed a genuine faith and robust rejection of suicide as theologically unacceptable to him. That he died amongst all this support made me question who could be safe. He died despite a steady stream of the best kinds of support.

Compounding the hardship of his death was all of the difficult conversations that lay ahead. I spoke to his pastor and his medical church friend who had referred him. What should I have done differently? Not knowing I had been his doctor, many of his church family and people from the local Christian community came seeking professional care from me about their grief over the loss of their friend. I was reminded afresh at the immense pain radiating from this tragic loss of life. About a year later, his widow was ready to bring her own questions about the last consultation, about his care, his death and trying to make sense of the unexplainable. How I wish my patient had pulled through! Although nearly two years have now passed, his death is rarely far from my mind. The inexplicable and uncertain threat of suicide often causes me to recall the death of this patient

"Despite all of my efforts, I recognise that nothing I can do can keep a person safe."

when I experience worry for other patients with concerning suicidal thinking.

I still grieve the loss of my patient, but not as one without hope (1 Thes 4:13-18). With certainty, I know that I will see my brother again; his vision and joy made perfectly complete by our Saviour.

Some Biblical Vantage Points on Suicide

Scripture encourages us to expect brokenness, pain and suffering in our fallen world.[1] We expect times of overwhelming grief and darkness. As examples, the book of Ecclesiastes portrays the pain of life's seeming futility and Job gives us a precious vantage point of a life in ruins under God's watchful sovereignty. Completely "*acquainted with grief*" and "*stricken, smitten by God and afflicted*" (Isa 53:3,4), Christ, our Great High Priest is able to sympathise with us in our weakness (Heb 4:14-15). Christ himself experienced excruciating loneliness in his suffering saying "*My soul is very sorrowful, even to death*" whilst his disciples couldn't even remain awake for him (Matt 26:28-46). Yet, no Christian will ever have to experience Christ's utter estrangement from God as he died on the cross. Despite this, the suicidal person may feel a sense of emotional familiarity with David's foreshadowing of Christ's isolation and suffering in Psalm 22:1-2: *"My God, my God, why have you forsaken me? Why are you so far from saving me, from the words of my groaning? O my God, I cry by day, but you do not answer, and by night, but I find no rest."*

Part of the potency of suicidal thinking is the extreme, categorical belief that 'things will *always* be this way' and that 'I will *never* recover'. There is entrenched helplessness and utter hopelessness. When not feeling suicidal, Christians can more readily identify such thoughts as the deception of Satan, who is by his nature "a murderer, … a liar and the father of lies" (John 8:44). Satan wants us to believe the heinous lie that it is worse to live than die. Contrast this with the life-giving words of our Creator and Redeemer: "I will *never* leave you or forsake you" (Josh 1:5, Heb 13:5). And Jesus' parting words "Behold, I am with

you *always*, to the end of the age" (Matt 28:20). The *always* and *never* of suicidal thinking are anaemic falsehoods when contrasted with the *always* and *never* of God's faithful love for all who believe.

There are remarkable similarities between the worldviews of the non-Christian and the suicidally depressed Christian; "The experience of unbearable pain, interpersonal alienation and hopelessness is similar. The struggle with unmet felt needs and the belief that there are no solutions to their problems is the same."[2] The difference is that we know God, and it is essential that we don't ever lose sight of him, especially in the midst of relentless hardship. God calls us to completely trust Him even in our pain and sorrow. He calls us to trust His promises and His character beyond what we can see and comprehend about our current situation and our future.

Consider Romans 8:38-39, *"For I am sure that neither death nor life, nor angels nor rulers, nor things present nor things to come, nor powers, nor height nor depths, nor anything else in all creation, will be able to separate us from the love of God in Christ Jesus our Lord."* This passage ought to both comfort and assuage the pain of a person considering suicide and also serve to reassure those of us who have lost a believer by their own hand.

Without a doubt, the Bible forbids murder, including self-murder.[3] Suicide is a morally blameworthy and culpable choice no matter how grievous the context. Scripture's references to suicide are universally negative, and each occurs in the midst of utter shame and sinful ruin.[4] God refuses every pleading request of Moses, Elijah, Jeremiah, Jonah and Job to take their lives.[5] For Jonah and Job particularly, God is highly critical of their plea. In an extraordinary article, Julie Gossack, who lost five family members to suicide, powerfully articulates,

> *"Suicide is a sinful choice by an individual. This statement is neither unloving nor disrespectful. It is the truth. I dearly love my family members that committed suicide, but their choices were sinful and not righteous … My family members believed the lie that their pain was greater than they could handle and that they deserved better than what God was giving them. They focused on relieving their own pain rather than considering the anguish they would do to surviving loved ones. They esteemed themselves above others. They failed to see God's goodness or sovereignty in their circumstances. Rather they put themselves in the place of God, the holder of life and breath, and decided they themselves were the holder of life and breath. They chose to lean on their own limited understanding and perspective instead of God's."*[6]

"More than any other factor, hopelessness is the single strongest predictor of suicide."

We are reminded that "*God is faithful, and He will not let you be tempted beyond your ability, but with the temptation He will also provide the way of escape, that you may be able to endure it.*" (1 Cor 10:13b). Paul provides a great example amongst others in Scripture who are wearied by the circumstance of life: "*We were so utterly burdened beyond our strength that we despaired of life itself. Indeed, we felt that we had received the sentence of death. But that was to make us rely not on ourselves but on God who raises the dead. He delivered us from such a deadly peril, and he will deliver us. On him we have set our hope that he will deliver us again.*" (2 Cor 1:8–10)

However tragic, suicide is ultimately a sinful means of self-centred rationalisation. Other sinful styles of thinking commonly abound in the suicidal person; anger, unforgiveness, bitterness and prideful entitlement. More than any other factor, hopelessness is the single strongest predictor of suicide. Hopelessness represents a sense of certainty that no solution exists, no escape, no good outcome - that all is lost. The future offers only misery, dread and despair. In contrast to faith, hopelessness fails to recognise the goodness, timing and wisdom of our sovereign God. Rather than death being the goal, suicide is often the means as a very tragic approach to stop seemingly unendurable suffering.

Suicide and Salvation

It is important to emphasise that despite its sinfulness, suicide does not nullify salvation. To doubt God's ability to forgive suicide, is to doubt Jesus' ability to atone for sin at all. Because all sins are covered by Christ's atoning death on the cross, there are no sinful circumstances leading to death which will remove a Christian's standing before God. The fact that suicide is the final act of life, doesn't invalidate the efficacious sacrifice which Christ has accomplished. "One dark moment in a Christian's life cannot undo what Christ did for us on the cross … Romans 8:38 reminds us that nothing will ever separate us from the love of God … When you stand before God, you won't be judged by the last thing you did before you died but by the last thing Jesus did when He died."[7]

God will witness evidence of a believer's faith throughout the entirety of our lives, not just our final minutes.[8] Mercifully, believers will be judged on the righteousness of Christ's life and death, rather than the unrighteousness of our own. Believers can still commit suicide, remain forgiven and spend eternity with the Lord.[9]

Losing people to the lies, hopelessness and half-truths of suicide should make us desperate to run to our loving Father for comfort. Our remedy is to trust in God's character and promises, to put on the full armour which God has provided

us and to remain held fast by our Saviour in His great salvation as we await the day in which:

> *"He will wipe away every tear from their eyes, and death shall be no more, neither shall there be mourning, nor crying, no pain anymore, for the former things have passed away".* (Rev 21:4)

How will I care for my next suicidal patient?

In addition to the normal medical cares, exploring history, circumstances and mental state, for my Christian patients I will aim to remind them of essential biblical truths which may have been clouded by depression. I'll seek to impress on them that Satan is a liar and a murderer (John 8:44) who lies because he wants to destroy you (1 Peter 5:8). I'll implore them "Don't listen to the liar. Listen to Jesus, the truth teller"[10] (John 8:32; 14:6). I'll encourage them not to usurp God's responsibility, and certainly not to seek a terrible ending to their life which will horribly impact their family.

For the non-Christian, I will suggest that no matter how they feel, that I am persuaded that genuine unshakable hope exists. That I will commit to walking with them while we manage their distress and seek out that hope. I will try to share the hope of the Gospel even in simple, brief references. I will pray for them, that God will reveal himself to them for the first time, or minister to them again. And whenever possible I will pray with them, a dynamic that is very regularly appreciated by non-Christian patients. These are once in a lifetime consults for most patients; to feel so severely unwell, to have disclosed so much. To offer prayer communicates that they are not alone - another person cares profoundly, and there is a God who will hear their cries too. Literally holding a person's hand as I reintroduce them to their Maker, I demonstrate how they themselves can reorient their sorrows, together we take a step in healing and recovery.

It is hard to imagine that I won't have other patients die by suicide. Having done all I can with my patients, it is good

to entrust them to the Lord. Unlike me, He is available and accessible 24/7. Unlike me, our loving God is infinitely wise, powerful and good. Unlike the finite public and private psychiatric support I seek for patients, God will never turn anyone away. What a relief that I can confidently refer all of my most life-threateningly suicidal patients to Him.

> ***"To offer prayer communicates that they are not alone - another person cares profoundly, and there is a God who will hear their cries too."***

As I petition God to do all that He wills and works in the life of my patients, I know that he is teaching me to love and care well. It is extraordinary that the Lord grants me the privilege of being involved in His work in people's lives, even when life and death hang in the balance.

References

1. Gen 3:15, Psalm 34:19, Psalm 119:67,71, John 16:33, 2 Tim 3:12, Phil 1:29, 1 Pet 4:12-19
2. Black, Jeffrey Making Sense of the Suicide of a Christian. *Journal of Biblical Counseling*. 18:3, p12. Spring 2000. Christian Counselling Educational Foundation. Glendale, PA
3. Gen 9:5-6, Exod 20:13, Lev 24:17, Deut 5:17, Matt 5:21-22, Luke 18:20
4. Scripture includes at least 5 references to suicide:

   Judges 9:52-54 - At the end of his murderous 3 year reign, Abimelech is trying to massacre a tower of trapped people. When a woman manages to crush his head by throwing a millstone down on him, he uses suicide to escape the shame of being killed by woman.

   1 Sam 31:3-5 - Saul's reign ends with defeat in battle. In shame he takes his own life by falling on his sword rather than be captured.

   2 Sam 17:23 - As his disloyal advice is rejected Ahithophel choses suicide to avoid accountability

   1 Kings 16:18-19 - Zimri murders the preceding king and rules for 7 days. As his treachery is discovered he suicides before he can be killed by others.

   Matt 27:3-5 - Crushed by guilt at his betrayal and the murder of Jesus, Judas choses suicide over repentance.
5. Israelites believed that suicide was an affront to the Lord, unacceptable no matter the context of level of distress. So Elijah asked the Lord for death (1 Kings 19:4) because he viewed the situation as hopeless. Job (Job 6:8–9) begs that God would end his suffering with death. Sinfully, Jeremiah wished he had been aborted by his father, in light of the sorrow and shame of his prophetic ministry (Jer. 20:14–18). Wedged between the complaints of the people and the anger of God, Moses rails against God "If you will treat me like this, kill me at once." (Num. 11:10–15). In contrasting prayers we see Jonah's self-centered hypocrisy; the same mercy he praises when receiving from God, makes him "angry enough to die" when granted to Nineveh, prompting him to beg for God to take his life. (Jonah 4:1-11)
6. Gossack, Julie. Life After the Suicide of a Loved One. *Journal of Biblical Counselling*. 24:1, p22. Winter 2006. Christian Counseling Educational Foundation, Glenside, PA.
7. Laurie, Greg Jerrid Wilson in Memoriam. accessed online 23/4/2021 harvest.org/resources/gregs-blog/post/jarrid-wilson-in-memoriam/
8. Piper, John. Funeral Message for Luke Kenneth Anderson. Accessed online 23/4/21 desiringgod.org/messages/funeral-message-for-luke-kenneth-anderson
9. John 10:28-29: "I will give them eternal life, and they will never perish, and no one will snatch them out of my hand. My Father has given them to me, is greater than all, and no one is able to snatch them out of the Father's hand."
10. Alcorn, Randy. Suicide, Heaven, and Jesus—the Final Answer to Our Sorrow. Accessed online 23/4/21 epm.org/blog/2019/Oct/7/suicide-heaven-jesus-sorrow

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Voluntary Assisted Dying

Christians participate in the voluntary assisted dying conversation in the truth that is in Jesus. A truth that is both particular and wide open.

We participate as people putting off an old lifestyle and now putting on Christ.

It is a life of transformation, not moral rehabilitation.

We are good news people, news that in love, God sent His Son to live and die on a Roman cross in Israel 2000 years ago. According to the apostle Paul, Jesus was Israel's long-promised Messiah. His coming deals with the problem of human sin and initiates the Kingship of God in the world, working like yeast in bread. Life as we know it, is irrevocably changing because of Jesus Christ. The door of history has been opened by God's grace. In this in-between time, the apostle Paul urges us to imitate God; as God's children, to 'live a life of love'. Daily we pray, 'Your kingdom come on earth as it is in heaven".

"Today" is one of these in-between days, when we pull aside to consider the proposal to permit euthanasia in our community. Many in our community see the passage of euthanasia bills as good news. Death on individual terms, without facing intolerable suffering. How do we confront this as the "good news" people?

I am a local Christian general practitioner, who has served the sick and dying in my community over 33 years. Euthanasia is a conversation which requires of us full attention to grace and truth. A conversation which requires we live and act from the embrace of the love of God. A conversation where we are promised the personal presence of the Holy Spirit.

Human rights are historically grounded in the Christian truth story. Yet we live in interesting times when God's rule and His love are effectively blindsided in public conversation. The rise in autonomy and choice as ways of living, leave ethical decisions down to a pragmatic sense of good.

> ***"Death on individual terms, without facing intolerable suffering. How do we confront this as the 'good news' people?"***

Yet, the world God made is good, and this goodness is part of the Christian good news.

Yes, the future of God's world will be a good future – sorrow and sighing will flee away. This again, is part of Christian good news. There will be trees whose leaves will be for the healing of not just individuals but nations as well. It will be the resurrection life. Life overflowing in joy and peace. Life lived out in faith, hope and love is good news come full circle. It is life's 'pilot study' mode now.

Many people have considered deeply the significance of death and its meaning and challenge to our lives. My role is not to go through ethical argument points. Although I could. The resurrection of Jesus promises to destroy death, and the resultant flourishing implies eternal life in the emerging new heavens and new earth.

So how does the Christian good news inform good ethical choices now?

Paul identifies three broad responses in 1 Corinthians. Some people consider the good news as "foolishness". It should be dismissed. They are failing to recognise that real change is emerging in our world. Christian arguments are not persuasive for them.

Some, it seems, found in the good news of Jesus, of God initiating an earthly kingdom, a stumbling block. New life, new creation was beyond their imagination. Such a particular vision of life is unacceptable in our liberal, pluralistic society.

Paul says a third group hears the gospel, the good news and believe it. Now we who do this, discover a transforming power in our own lives and indeed, all of creation. These responses recur as the good news is announced through the ages.

Because it is centred in love, the good news is life-affirming news. So, what is my experience of 'life' in our Bayside district where I work?

Many people genuinely enjoy life in Bayside. In God's providence, most of the ingredients for a flourishing life are accessible right where we live. Waterfront access, accessible work and recreation opportunities, good schools, shopping facilities and churches.

However, the picture is not uniform. Some of us struggle without work or a stable home. Some have very limited experiences of love and dignity. There is sickness, sorrow, suffering and at times despair. For some, life bumps along close to intolerably.

In the patchwork, there are many beautiful days. Days of delight. There are many services and individuals who bring compassion, love and hope to our lives. Transport, Meals on Wheels, community visitors, community nursing, libraries, schools and so on. Our churches mirror these rhythms. We are called to both celebrate and be patient in the power of God's love. None of us seek an agonising death.

As I have described, there are many resources in our community, and most

people with good psycho-social-spiritual-physical and medical care die with peacefulness. Some don't, a minority.

Our community is blessed with palliative care and other care resources. Political will has not been able to extend this to all Australian communities. This feeds a sense of restlessness about the pathway to death in the broader community.

> ***"By removing the possibility of physician-induced deaths, the Hippocratic tradition restored public trust in doctors, and this has been sustained now for 2,500 years."***

What our world is saying these days is 'no' to fake news, including fake news about palliative care. We must not overstate our case.

My experience as a GP committed to whole-of-life generalist care, including palliative care, is also both positive and negative. Some people in their family contexts embrace death. They die well and mostly surrounded by love. Some find dying distressing, they suffer and are unprepared. Some are angry and frustrated that good plans, good friendships must end. My experience replicated by other palliative care physicians, is that with good help, much distress can be alleviated. We call this palliative care.

So why am I committed to a palliative approach?

1. Hippocratic medicine arose in the context of involuntary assisted dying. Greek physicians responded to inadequacy and the impossibility of therapeutic interventions by prescribing a poison to end suffering and also protect their reputation. This resulted in distrust and avoidance by people needing health care. By removing the possibility of physician-induced deaths, the Hippocratic tradition restored public trust in doctors, and this has been sustained now for 2,500 years.

2. A Christian pro-life worldview merged easily with the Hippocratic approach and also introduced social justice perspectives.

3. Over the past 32 years I have contributed to the care of nearly 1,000 people in the Wynnum/Manly community who have died. While death was both inevitable and often complex for these people, few died a "horrible death".

4. The rise of the palliative approach in the modern context has witnessed major advances in the relief of both physical and existential suffering. Science can continue to inform better approaches. So should theology.

5. Life-long learning principles support community GPs to stay with the best practice approach to palliation.

6. The rise of community-based team care and specialist palliative services and hospice facilities have also been very positive developments.

7. To a great extent, we are the stories we tell. Dying is a phase of life to reminisce, to laugh, to heal wounds, to tell each other that we are lovers. In a world of autonomy, our self remains intrinsically communal. Palliative care harnesses the communal reality of life so that death can become a gift to those we leave behind. Palliative care shows there is a better way than the 'Scottish' "blue pill" or Facebook "unfriending" in the context of suffering. GP palliative care enters seamlessly into our story telling worlds.

I return to my primary argument. Intellectually, we recognise the good news, gospel news is pro-life. Life is a gift, a glorious gift.

Intellectually, we can recognise a tension when the good news reaches out to the terminally ill, the despondent and marginalised with its pro-life calling.

Is this resolvable?

Christians can start to respond by being the good news: "They will know we are Christians by our love" are Jesus' words. Christians will love their neighbours as themselves. We will enter our community with respect, compassion, patience and hope. Many cry out: "Send somebody to love me!" As we love, we will kindly remind our neighbours of the good news. The incentive for serving needy neighbours is that this is both the way to follow Christ but also a way to encounter Christ himself. The text of Matthew 24 encourages such a vision. A challenge remains.

Will we be willing to love if neighbours choose Voluntary Assisted Dying (VAD)? Will we respectfully maintain a cruciform presence in the context of such despair? God's entry into the life of the world in Jesus, extended to his voluntary surrender to death on the cross – it was love at full stretch.

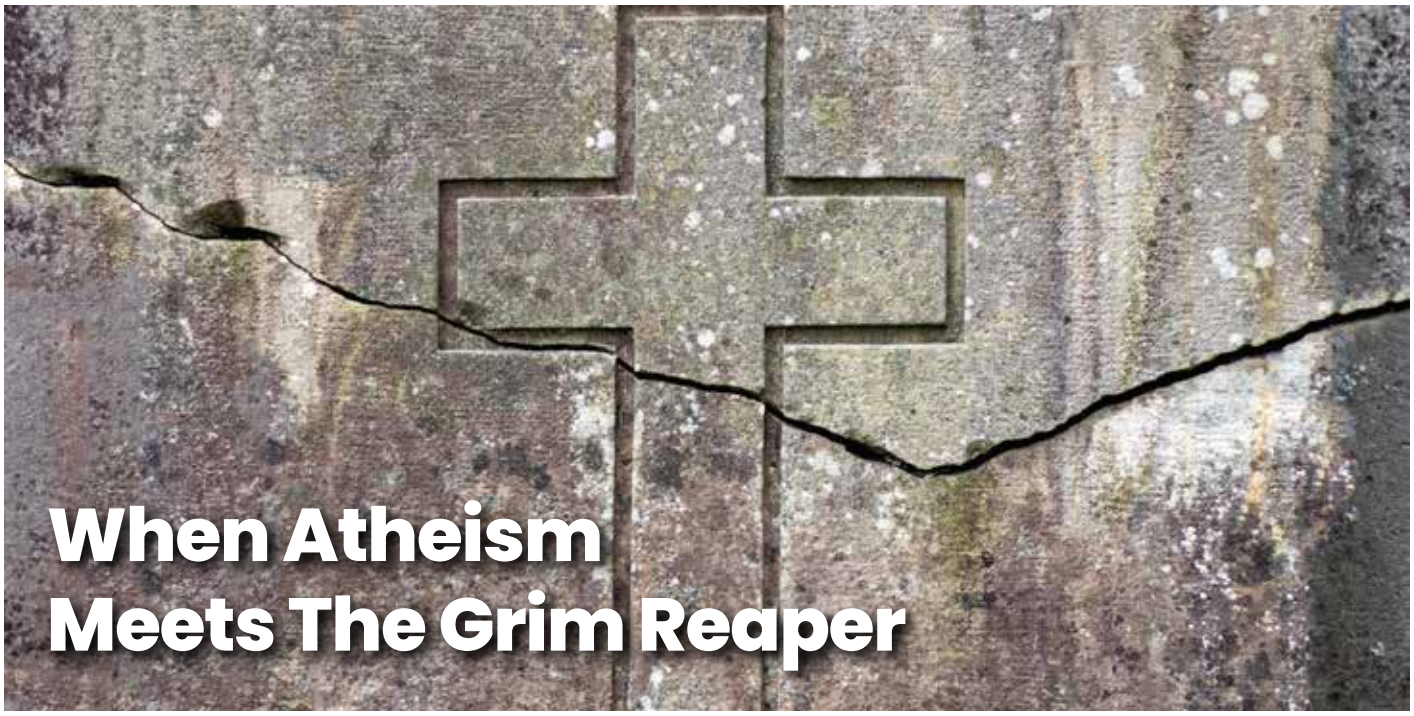
Today is a time to speak the truth and be the truth – good news truth in love. Life is a wonderful gift to be entered into, as a creation-forming partner with God.

Tomorrow, our calling may be to go the extra mile of love, with neighbours who embrace the prospect of VAD. We will need to adapt with grace in such a world. We can embrace such neighbours, knowing the future of death is secure. It is good news that the sting of death is settled in Christ and death's power is being withdrawn as the kingdom comes.

Christ humbled himself as a servant. Our calling is to follow in his steps, to live in Christ – indeed daily dying and living with Jesus. Let us be ethically robust 'good news' people, and let us love radically as 'good news' people.

(The content of this paper was presented at a public Australian Christian Lobby event in Brisbane, August 2019.)

Emeritus Professor Geoffrey Mitchell
Geoff is Emeritus Professor of General Practice and Palliative Care at the University of Queensland, who retired from academic practice in 2019 to return to full time general practice. His main research interests are in primary palliative care research, integration between GPs and the care of chronic and complex medical problems in primary care.



When Atheism Meets The Grim Reaper

Vinnie* was big, both in presence and size. As an Italian, he had a lot to say and was not afraid to speak his mind.

He grew up in a religious family. He escaped this when he went to university where he found his voice as an avowed atheist. He was a self-made man who ran his own manufacturing firm. He was clever with his hands- an artisan in his spare time. From a worldly sense, he was a very accomplished human being and as a patient, a very interesting sparring partner. We got on well, even though I knew that a visit from Vinnie was going to run well over time. We always booked a double appointment.

We met because he was referred to me. He was dying, of not one but two cancers, one of which caused very troublesome and obvious symptoms. Vinnie was emphatic that he wanted no pain or distress in the end. He would rather be euthanised than to suffer, and for me to assist him in doing so. Over the course of several consultations I respectfully told him that I could not and would not do this. It was against the law. But primarily, my job was to minimise his suffering and allow him to live what life was left, to the full. Vinnie struggled to understand why he did not have the right to end it all before he suffered too much.

Vinnie had plenty to live for. He had a delightful wife, four children and several grandchildren. His life was wrapped around his family and enjoying his craftmanship.

His symptoms, predictably, were difficult to control, but we managed to negotiate our way through. Every visit, he would start with a loud denouncement of my ability to keep him symptom free. Why can't I just end it all for him? We'd then work out what had to be done for his symptoms and adjust his treatment. The consultation would conclude with him more or less satisfied and with a lopsided grin.

One day, well into his physical decline, he presented not as his usual jovial self, but shaken. He experienced panic attacks and insomnia. He was tearful. He couldn't understand what was happening. To me, it was clear. His reasoning was catching up with his illness. He was dying. And he was dying as an atheist. He was about to lose absolutely everything; his pleasures, his family, his possessions – everything. All he could see was nothingness, and this was terrifying him.

> ***"He would rather be euthanised than to suffer, and for me to assist him in doing so."***

So what could I do? After pointing this out, Vinnie reiterated his atheistic stance. He said his fate did not worry him. He was not anxious! He knew I was a Christian and he wanted nothing to do with it. Needing further advice, I had consulted a Christian psychiatrist who specialised in psycho-oncology. Her response to his bravado – Bull***t! So here we were aiming to alleviate distress yet not able to offer anything that would assuage the most terrifying prospect of all.

The psychiatrist suggested that the only thing that could be done was to encourage Vinnie to work on leaving a legacy for his kids and grandkids. He did do that, and it gave him a lot of pleasure doing so. Eventually his symptoms caught up with him and he was referred to the palliative care unit for advanced symptom control. He died in hospital

having spent all but the last week or so of his life at home. All in all a good, but ultimately sad, outcome. What a waste.

Vinnie gave me a lot of food for thought. The book of Ecclesiastes, as Tim Keller explains, is a series of thought experiments where the Teacher considers the fate of a life lived only for the things this world can offer – pleasure, wisdom, and success. The Teacher concludes that the consequence of each of these was Meaningless, a chasing after the wind, and nothing was gained under the sun. (Eccl 2:11b). The realisation of this hit Vinnie hard towards the end of his life.

What does the Christian faith offer?

Further on in the chapter, the writer brings God into the scene. He states: To the one who pleases him, God gives wisdom and happiness (Eccl 2:26). Life is most fulfilling when it is lived for God. Paul writes: Follow God's example, therefore, as dearly loved children and walk in the way of love, just as Christ loved us and gave himself up for us as a fragrant offering and sacrifice to God. (Eph 5:2) For a doctor, walking in the way of love means walking as Christ would walk with those who had no hope, and offering *agape* love along with our medical skills. *Agape* love is loving a person without expectation of something in return. It is something most people rarely experience, and something we as health professionals have the privilege of offering to others every day.

I firmly believe we have the right to present Christ to our patients by offering *agape* love and building trust. When the time comes, we can then raise the glorious riches of this mystery, which is Christ in you, the hope of glory. (Col 1:27), and know that this will be heard. How they respond is up to them.

*Details have been changed for anonymity.

Dr Michael Nicholson
Michael is a retired rural GP currently living in Newcastle.

CMDFA End of Life Resources

"Were you there when they hung him on a tree? Were you?"

The haunting tune and stark question in this hymn from Africa shocks us out of our relatively safe and free lives. Can you imagine if we had been there?

Even most of the Apostles were not there.

That Christ, God - yet truly Human, went through the unimaginable brutality of being crucified, forces us to face the reality of that great lesson ancient Judaism gave the world (on which our own civilisation is based):

"Thou shalt not (kill) murder"

Of course we, "Tremble, tremble ,tremble," to realise that our nation is legalising killing in the name of compassion.

Not that it is many years since we ceased to kill criminals.

Oh yes - all the safeguards get written into law, and then are quietly watered down when the shouting and the tumult dies.

Children, we now hear - below the age of consent - are being euthanised; as are those with dementia - without the capacity to give consent - even being sedated beforehand to make it more dignified for the killers!

Compassion starts with Care. Care offers Hope and, with Palliative Care, the tri-unity of spirit, soul and body come together to encourage the growth that brings a Good Death.

The case for Palliative Care and not Euthanasia is sensitively and expertly put by Dr Megan Best in two CMDFA resources: Euthanasia (booklet form[1]) and End of Life care seminar (in 6 20-minute podcasts[2]). Two further 15-minute videos are available from the CMDFA office at office@cmdfa.org.au.

They are a valuable addition to bringing reason back to the debate.

References

1. https://www.cmdfa.org.au/articles/euthanasia-response
2. https://www.cmdfa.org.au/ethics

Dr Martha Mherekumombe

Martha is a paediatric palliative care physician working in Sydney. Originally born in Zimbabwe, she grew up in Zambia and migrated to Australia 24 years ago. She is a single mum to two amazing adult daughters. Martha loves to cook, walk and watch movies. She is an active member of the community, passionate about health and wellness. She is also the Vice President of Zimbabwe Doctors in Australia, and co-founder of Flame Lilies of Hope helping to develop better care for children in Palliative care in Zimbabwe.

Photo: Annie Spratt, Unsplash

Dying Young

Caring for the Critically Ill Child and their Family

I often get asked why I work in Paediatric Palliative Care. It is a most rewarding and fulfilling job.

I have the honour and privilege to walk alongside some special families, children and young people doing the journey of life. Working in this area has taught me much and strengthened my faith. There have been challenging days where my faith has been tested, but I believe I am called and have been chosen to work with critically ill and dying children.

Together for Short Lives defines Paediatric Palliative Care (PPC) as palliative care for children and young people with life-limiting conditions as "an active and total approach to care, from the point of diagnosis or recognition, throughout the child's life, death and beyond". It embraces physical, emotional, social and spiritual elements, and focuses on the enhancement of quality of life for the child/young person and support for the family.

PPC does not take away hope. Instead, it enhances the child's short life. It's about living, not focussed on dying. Dying will eventually happen, but until then it seeks to maximise the time the family has, and ensure that the remaining families survive intact. The PPC approach is not an either/ or approach to medical care, it is about integrating care of the whole patient ensuring that the child, young person, siblings and family's needs are met. These needs are met through good medical practise and palliative care which fosters and develops trusting relationships with families early. When we establish a partnership of trust we achieve more and the partnership becomes a healing one.

This is the same in our personal walk with Jesus, Proverbs 3:5-6 KJV directs us to -

'Trust in the Lord with all thine heart; and lean not unto thine own understanding. In all thy ways acknowledge Hhim, and He shall direct thy paths.'

"When we establish a partnership of trust we achieve more and the partnership becomes a healing one."

The years I have worked in PPC, has taught me much about this. As a mother, working with very sick and dying children can be confronting and some children and families have a greater impact on us than others. I value the importance of that Scripture as it confirms the sovereignty of God because I cannot understand His ways. Conflict or ethical issues in PPC such as withdrawal of interventions or medical care, can unravel our faith and beliefs. In these situations I am often reminded of what Apostle Paul wrote in Philippians 1: 9-11 KJV-

And this I pray, that your love may abound yet more and more in knowledge and in all judgment; That ye may approve things that are excellent; that ye may be sincere and without offence till the day of Christ; Being filled with the fruits of righteousness, which are by Jesus Christ, unto the glory and praise of God.

My understanding of the knowledge spoken about here as having a spiritual awareness and judgement is wisdom. One of the main domains of PPC is providing spiritual care. Attending to the spiritual needs of the child and family helps them to seek meaning of what they are going through and assists them to

find hope and comfort. Spirituality does not only refer to religious beliefs and values but rather has to do with our search for meaning. It is connection to something greater, finding purpose in life. Spirituality in children and young people with serious illnesses and dying, includes their knowing that they are unconditionally loved, safe, secure, and will not be forgotten. When this is lost, spiritual suffering manifests as feelings of hopelessness, grief and uncertainty of the future.

A few ago, I experienced a challenging time at work caring for a young teenage lady. She loved life and was happy and bubbly, with hopes and dreams of finishing school, having a boyfriend and working. Despite her disease progression, she maintained hope and the expectations of a long, enjoyable life. Walking onto the ward one morning she was sobbing hysterically and uncontrollably. It was heart breaking because she did not want to die and was begging us to help her live. That was terrible to witness and Medicine does not prepare or teach you how to handle situations such as this. At that point I doubted why I was working in PPC. We eventually calmed her down with the help of the Chaplain by addressing her spiritual suffering.

The work we do in PPC requires us to care for ourselves. Without good self-care it is impossible to provide the care and support the families require of us. And it can impact our faith in God. I finish here with Psalm 139:1-14 KJV which is a special psalm for me.

O Lord, Thou hast searched me, and known me. Thou knowest my downsitting and mine uprising, Thou understandest my thought afar off. Thou compassest my path and my lying down, and art acquainted with all my ways. For there is not a word in my tongue, but, lo, O Lord, Thou knowest it altogether.

Thou hast beset me behind and before, and laid thine hand upon me. Such knowledge is too wonderful for me; it is high, I cannot attain unto it. Whither shall I go from thy spirit? Or whither shall I flee from thy presence? If I ascend up into heaven, Thou art there: if I make my bed in hell, behold, Thou art there. If I take the wings of the morning, and dwell in the uttermost parts of the sea; even there shall thy hand lead me, and thy right hand shall hold me. If I say, surely the darkness shall cover me; even the night shall be light about me. Yea, the darkness hideth not from Thee; but the night shineth as the day: the darkness and the light are both alike to Thee. For Thou hast possessed my reins: Thou hast covered me in my mother's womb.

I will praise Thee; for I am fearfully and wonderfully made: marvellous are thy works; and that my soul knoweth right well.

Dr Susan Cheah
Susan has worked over 25 years in General Practice in Sydney's Inner West. She loves the community and continuity of general practice and is part of her local church, reading the Bible with women of all ages.

Beyond a Precious Life

Photo: Fallon Michael at Unsplash

Every story is unique. **Grief is a journey you largely walk on your own, that even those closest to you can really only observe.**

Every story is the same. Everyone in this life will experience loss, pain, suffering and struggle.

My story…

I was pregnant with twins, conceived with the aid of fertilisation treatments. A miracle? Answered prayer? A medical success story? A blessing. But at 25 weeks into my pregnancy I went into labour. Hospitalisation, infusions started. Medical staff buzzed around. Hope was discussed that this labour could be stopped.

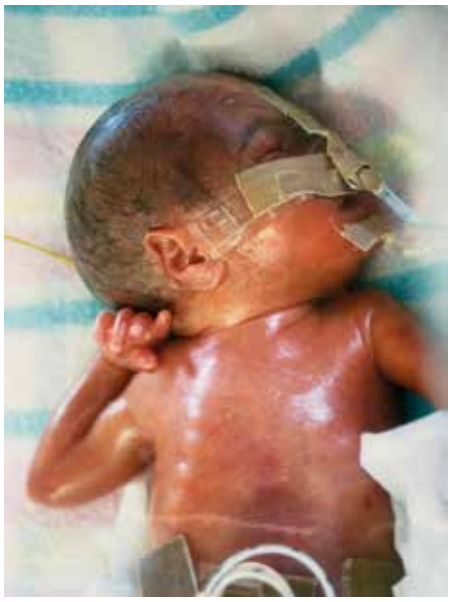
My obstetrician walked in, made his assessment, and spoke these words, "These babies are coming … the delivery is imminent."

And with that my world stopped. It was if the world was now spinning on a different axis. How was my life unfolding? Dreams, hopes, expectations … all teetering.

Statistics were given … Such early delivery has risks of cerebral palsy, development delay, chronic lung disease, visual and hearing impairment, intellectual disabilities and of course a high mortality rate.

So our gorgeous twin boy and girl were born at 25 weeks. Our daughter died on day 3. Our son survived (pictured below). Having endured many challenges, he is now a young adult.

From my experience, what would I say about how we health care professionals, who stand by our patients' sides, can help our patients on their journey?



1. **Value life.** Every life is precious, including that of the unborn child, the disabled child, the sick. Have we taken on our world's economic view of a life, that a life is only worth living if we can achieve and excel? Or do we see each person as precious, with innate value as one made in the image of God? Worthy of the best medical care, worthy of our time and compassion, worthy of our efforts, worthy of our tears. Are our beliefs reflected in our practice, in how we treat and care for our patients?

2. **Step in.** Grief is a lonely journey but we can walk beside people. The emotions can be confronting, we are often forced to face our own fears, but be courageous, look beyond your own pain, rely on God's Spirit working in you and be there for those who need you. Step into our patient's lives. With God working in us, we can do more than we would think is possible.

3. **Grieve with them.** It's not about providing solutions or fixing things for people, but sitting with them in their

pain. Be in their darkest hour. Don't diminish their pain. Mourn with them.

4. **Pray with them and for them.** We have an amazing God, who knows our painful moments, who desires us to bring all our burdens to Him who is the only hope, who holds us in His hands. Emotions can be so overwhelming and we have no cure for suffering in ourselves. So point those who are entrusted to our care to the one who is the God of all comfort. Encourage them to turn to God. And when we ourselves are burdened, also bring our griefs to our God.[1]

"Point those who are entrusted to our care to the one who is the God of all comfort."

5. **Don't forget.** Grief is with us for all of this life. It changes the person in every way. It is with them in every moment so be aware. Look out for those times they need extra support and help. Remember anniversaries, foresee difficult circumstances and offer care.

We who know the only hope there is in this world, who have the words of eternal life, need to be a light in people's darkest hour.

> *When Jesus spoke again to the people, he said, "I am the light of the world. Whoever follows me will never walk in darkness, but will have the light of life."*
> (John 8:12 12)

Reference

1. Vroegop, Mark. *Dark Clouds, Deep Mercy: Discovering the Grace of Lament*. Crossway Books. 2019. (A great book on praying through our grief.)

CMDFA Luke's Journal

Instructions for contributors

Members of CMDFA are invited to submit articles or letters to the editors for publication in Luke's Journal. Articles may or may not be on the advertised theme. Writers may wish to discuss their potential contribution with the editors or their state editorial representative before submitting.

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

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

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

Rev Jenny Busch
Jenny serves as the Uniting Church chaplain at the Queensland Children's Hospital and the Mater Hospitals (South Brisbane). She is a member of the ecumenical Order of Jacob's Well which informs much of her theological framework. Previously, Jenny has served as a secondary school chaplain, worked with programs responding to child and family violence, and done supply (interim) ministry in several Congregations. Jenny is married to Rev David Busch.

The Life-Giving Work of Paediatric Palliative Care

Photo: David Beale at Unsplash

The prospect of working in paediatric palliative care at first seemed daunting to me. Facing the death of a child is a spiritually demanding time, when many families would be seeking a miracle, and I knew I couldn't fulfil their hope.

The key for me has been moving my vision from sickness and death to the life-giving love of God expressed in Jesus and his completed work of the cross. This has not only helped me to carry the load of this work, but to do so with joy.

Here are some of the learnings and experiences that sustain me. I hope these might inform and sustain others as well.

Knowing my role boundaries

Although there are different approaches to pastoral care, as a Christian minister my pastoral care grows out of the good news of the Kingdom of God, best revealed in the life, death and resurrection of Jesus Christ.

Of course, I am mindful of the essential pastoral disciplines, and the important pastoral consequences, which must inform my interactions with children, families and staff. I also must respect the boundaries that the hospital places upon me as a chaplain.

But my primary task is, in word and sacrament, to help people discover the life-giving presence and power of God who already has defeated the power of death on the cross. What a joy!

I do this by listening for evidence of where the Spirit of God is at work in each context and flow with it. I listen for where fear speaks lies into a situation, and I seek to defuse its power by affirming the truth of Christ. In places where death tries to declare its victory, I bear witness to the victory which Christ's death and resurrection have accomplished.

> ***"In places where death tries to declare its victory, I bear witness to the victory which Christ's death and resurrection have accomplished."***

While to the public I am known as a minister, I know that I am living and working within *Christ's* ministry and the continued outflowing of what he achieved on the cross. My task is not to draw attention to what I do, but to what Christ has already achieved.

In this sense, it is important that I do not fall into the trap of title and position. Some patients and families want to elevate me or depend on me; others want nothing to do with me. I have come to understand that it has very little to do with me at all.

I play a support role to Christ who offers his ministry to patients, families and staff. As they respond to their situation in faith, through conversation, questions and actions, together we explore what it means to live in God's grace.

Jacob's story*

A paediatric palliative care nurse called me to come and visit a family. I walked into a three-bed ward and encountered five-month-old Jacob, who was screaming inconsolably. The mum was South Sudanese and English was a new language for her, adding to the complexity and tension of the moment.

The nurse explained that mum was Christian, and after introducing myself to her and thanking her for inviting me into her journey, I asked for permission to speak to her son. With her agreement, I introduced myself to this little baby.

I told Jacob about how God loved him so much that God came in Jesus to help us know the power of God's love. I told him that although he might hear some doctors and nurses say that he was going to die soon, he didn't need to worry because Jesus had already died. Jesus had gone ahead to make a way for him, and beyond death was another life with even more freedom and joy.

Together we celebrated that his name was shared with a man in the Bible with whom God entered into a special relationship, and that God had a special relationship with him as well.

Jacob stopped screaming. Some said he even had a smile on his face, and after being changed by the nurse he was placed in his mum's arms. Everyone was amazed. In the midst of his physical distress, Jacob seemed to find a spiritual peace as he heard about Jesus. The head nurse asked if I would come back every day, even twice a day. After seeking mum's permission, that is what I did.

Only later did I discover that because of the fragility of this little boy's medical condition – congenital cardiac disease, pulmonary hypertension and Type 2 respiratory failure – mum had never held her son before that day, something she had longed to do.

A couple of weeks later, a ward nurse rang me to say Jacob was dying. I said I was unable to come immediately but I would be there as soon as I could. Aware of the spiritual connection which Jacob and I shared, she asked, "What should I do for him spiritually?" I replied, "Tell him about Jesus."

Arriving at the hospital some time later, I discovered that Jacob had died peacefully in the nurse's arms.

Prayer: Resting in what Christ already has done

Working in a government hospital, I am allowed to visit only those patients and families who ask to see a chaplain. It is essential that I respond to their wishes and not my own desires.

> ***"I believe the completed work of Christ on the cross spoke life, strength and hope into her that day, and her life then brought joy and hope to many."***

When people ask me to pray, I always agree. Where appropriate, I ask them how they would like me to pray. Some common responses are:

1. Jesus you healed on earth – please heal me / my loved one.
2. God, I pray not my will, but your will be done.
3. God, I am sorry for my sin. Please take this punishment away.
4. God, give us enough faith so that I / my loved one can be healed.
5. Jesus, thank you that, through the cross, we are brought into your life-giving presence.

I pray the last way, mostly because I believe it best reflects the response we can make to what Jesus accomplished on the cross, by receiving it – everything has been done, and we do not need to ask for more.

Leah's story

The first active case I worked on in paediatric palliative care was Leah, a 5-month-old girl who sustained Hypoxic Ischemic Encephalopathy caused by an incident at home. I had been praying with mum and dad during her stay in Paediatric ICU (PICU).

When Leah was diagnosed as palliative, the family was invited to consider the withdrawal of life-sustaining measures. Mum was reluctant, and after some days she said to me, "Jesus was in the tomb for three days. I just want three more days." I negotiated a 3-day extension to their stay.

At the end of the three days, I was with mum in PICU. She knelt on the ground and asked me to pray as I laid my hands on both her and on her daughter in bed. My prayer was along these lines

Gracious God: Thank-you that you love us so much that you came in Jesus to help us understand your loving nature. Thank-you that, because Jesus healed everyone who asked, we know that anyone can come to you and receive your unconditional love.

It does not matter how old we are, what we have or have not done. It does not matter what culture we come from, or our religious background. You came for each of us. Thank-you that the healing which Jesus offered is now offered to all people through the cross.

Today we receive that healing for Leah, and we open her and ourselves up to receive more fully your healing grace. We entrust her to your loving care and watch for the ways the fruit of your life-giving love may grow in her life. Amen.

Shortly afterwards, the machines were turned off and little Leah breathed on her own. Was it because of me? No. And Leah continued to have complex and serious medical needs and died at another hospital four years later. But I believe the completed work of Christ on the cross spoke life, strength and hope into her that day, and her life then brought joy and hope to many.

Fullness of life is already available

The life-giving miracle of Jesus has already occurred. I do not have to convince Jesus to do anything more for me or for anyone else. Rather, Jesus

invites us to rest into what he has already done for the whole world on the cross. My role is to help others hear the good news and rest into the kingdom of God in which they are held by grace alone.

I once explained it to an adolescent this way: praying "Jesus, please heal me," is a bit like asking your parents for $20 without realising that they had already put $1000 into your bank account.

The purpose of prayer, then, is to focus on the truth that Jesus – Emmanuel, God with us – has, through the finished work on the cross, defeated the power of all things that would separate us from God. Focussing on that truth allows the power and hope of that reality to flow to us more freely.

As Dean Drayton writes:

> *"[Faith] is about being able to name the God who is present. When Jesus says, 'Your faith has made you whole' his attention is on the person who is asking for healing. He acknowledges that the person has recognised that the healing God of the Kingdom of God is present. Because God is present or the Messiah is present, or the kingdom of God/Heaven is present, then healing can occur. The subject has recognised who can bring this about and has come in his presence.*
>
> *When a person is able to name this God, it is to know God has already found them in and through the death, resurrection, and ascension of his Son, and places us in Him. … The consequences follow: we then experience that we are at peace with God by God's act, and have obtained access to God's grace, which opens to us this new creation in which we are found in Christ."*
>
> (*Apocalyptic Good News: Christ in the Cosmos,* by R. Dean Drayton, 2019, page 222)

Another way to describe this dynamic is that, when praying, it is best to say "thank you" for what Jesus has already done rather than "please do more". There is

"God has already taken away the power of death and offers all of us life, whether that be beyond death or living here on earth."

nothing more for Christ to do. He finished his work on the cross. Through the Holy Spirit, His grace continues to flow.

Through this theological lens we see the answer to the question, "Why won't God heal my child?" God has already taken away the power of death and offers all of us life, whether that be beyond death or living here on earth.

Following Jesus

> *"No sick person was ever commanded to sort their own lives out first before they could receive healing. He (Jesus) never gave up halfway through. He never discerned the Father's will in matters of healing to be anything other than "Yes and Amen". He said that he only did and said what he saw the Father doing in heaven. Jesus is, after all, the only perfect image of the invisible God."*
> (*The Blind Healer*, by Mike Endicott. 2011, page 159)

There is no record in the gospels where Jesus asks God to heal someone. Moreover, many healing accounts in the gospels indicate that Jesus was teaching and proclaiming the Kingdom of God and people were healed.

If I am to do what Jesus did, as a disciple of his, then the call is for me to tell people about the Kingdom of God, best expressed to us through the life, death, and resurrection of Jesus. It is through God's act in bringing us into his presence that healing is made available to us.

Now it is true that well-meaning Christians have done a lot of damage in the way they have thoughtlessly proclaimed the Kingdom of God. The pastoral element of a chaplain's ministry, indeed the ministry of any Christian, is to listen for where the story of the Kingdom of God intersects with the story of the patient and family, to affirm true links and challenge falsehoods in a way that is culturally and situationally appropriate.

Some examples include:

Comment: "I don't know why God has sent this suffering to me."
Response: "Jesus helps me know that God took suffering upon himself rather than inflict it on others."

Comment: "Is it God's will that my child die?"
Response: "Jesus shows us that God's will is that no-one dies, that is why he died to offer eternal life."

Comment: "Is God punishing me for not going to church?"
Response: "Church attendance is not a requirement to receive God's love. Besides, the Bible affirms that Jesus took all our punishment upon himself, so he didn't have to punish us. This does not rescue us from the natural consequences of human behaviour, but it does assure us God is not punishing us."

Of course, all these comments are out of context and are only examples of intersecting points. Chaplains learn what to listen for, as well as to wait for patients to initiate exploration.

Prayer plays an important part in the ministry of healing – physical, emotional or spiritual – and sometimes it is when we pray with or on behalf of a patient or family that we proclaim the kingdom,

just by the affirmations and attitudes we articulate as we talk with God.

Miraculous healings never happen as a result of any human action. When they happen (whether we see them or not), it is always as an outpouring of God's grace released to people whom God enables to hear and receive it in their time and space.

Christ's death and resurrection are for all

In my role, I celebrate daily that the work Christ did on the cross is open to all people. I can offer it freely to anyone, even if they do not believe they are eligible. Christ died for all.

Being in a small chaplaincy team, I am often asked to help connect patients and families of various faiths with pastoral leaders from their own religious tradition. Sometimes they invite me to journey with them as well, or instead.

When asked to pray, I take my cue from how their religion regards Jesus as to whether I refer to Jesus, or take a less specific approach and refer to God. But I am committed to affirming that God's will is life for all, and God's grace is freely and abundantly present for every person in every situation.

When death comes

Death comes to us all. How does the cross of Christ help us understand loss through death?

Pastorally, we affirm that God is not distant or impassive in the face of human mortality, but that God has entered into the fullness of human experience in Jesus Christ, including suffering and death.

Theologically, we celebrate the gift of eternal life, however we understand that to be expressed.

Practically, we understand that the experience and impact of grief varies from person to person and takes time to integrate healthily into life.

While medical staff often meet and reflect on the professional and personal aspects of a patient's dying, and while all of us are challenged to reflect on the meaning of our own life when we attend funerals, Jesus' death and resurrection is the cradle by which I hold all other deaths.

I am thankful for the opportunity to rest into the love of Jesus and to invite others to do the same. While Jesus came to serve humanity, we are not Jesus' boss. We are invited to boldly accept our relationship in Christ. We cannot demand an outcome, but rest into the outcome he has already given us of his own death and resurrection.

Each Lenten season, we recall the intentionality that Jesus gave to preparing others for his death. Despite all his efforts, no-one really understood what was to occur, and upon his death his mother was devastated and his disciples felt hopeless, abandoned, and afraid.

This enables me to normalise the wide variety of reactions from family and friends when a loved one dies, and to do so without judgement or fear.

It is no surprise that after his resurrection, Jesus appears first to his closest friends and family, offering peace and hope of his eternal life. Some immediately are filled with joy, others with questions and doubt, and some with fear.

Tracing Peter's encounters with the resurrected Jesus helps us to know that Jesus will continue to speak life and hope and belief in us even when we do not believe in ourselves, let alone him.

Sometimes I will be a person who speaks a life-giving word to another, and sometimes someone else will do that. When I wonder how bereaved families and friends are going, I trust that, while each of us have our good and bad days, God is continually speaking life and hope and peace to them because that is what God speaks to us all.

Understanding this helps me set clarifying boundaries about what is mine to carry, and what is not. It enables me to hold to a future vision that is hopeful for the children and families we care for, along with the hospital department and staff.

Postscript: Andrew's story

I first met Andrew when I was the chaplain at his sister's school and met with the family. Against all expectations, he was aged 9 and energetic, happy and sociable – at two, he had been diagnosed with Type 1 Neurofibromatosis and given three years to live.

The family was active in church, and Andrew articulated a lively commitment to Jesus which brought him much joy and was the inspiration for his deep care for others over his own profound struggles. I engaged regularly with Andrew and the family over the next six years, and noted how much more at peace Andrew was about his deteriorating situation than his family.

By 15, he had reached the point of needing full-time hospice care. One day, as it was clear that Andrew was dying, I offered to come and share bedside Holy Communion with the family. But when I arrived, Andrew was unconscious, and within minutes he died.

Raw with grief and shock, Andrew's father, mother, sister and I still shared Holy Communion, partaking of the bread and grape juice within a simple liturgy recalling Jesus' last supper with his disciples the night before he died. The liturgy spoke of all of heaven and earth joining in every moment that Christ's death and resurrection is remembered in this way.

With tears, and amid our pain, we trusted that Andrew was sharing in that Communion service with us, not with bread and juice but in the real presence of the Christ who died for him and raised him to life.

We were not only with him until the very end. We were joining him in his new beginning – in the eternal celebration that Christ's life, death and resurrection has given us life beyond death, always held in the mystery of God's grace and love.

* Names used in stories in this article have been changed.

Dr Emily Isham
Emily is a women's health GP living in Tasmania with her husband, Seth, and their four earth-side children. They have just emerged from years of turmoil, caring for their son, Ned, through his aggressive leukaemia, the consequent interstate and overseas travel for treatment and bone marrow transplants, and palliating him back at home till he went to Jesus in March 2019.

Reflections of a Grieving Mother

"Lucy, Ned's leukaemia has come back again. And we won't be able to get rid of it this time."

"Why, Mum?! It's not fair! Why has God let this happen?"

"My darling girl, I'm angry too. And so, so sad. But given Ned was going to get leukaemia anyway, and nothing to our knowledge would have prevented this, given he was born into his short life, aren't we fortunate that God chose our family to have Ned?"

I tell her that. I tell my other children that. But in reality, I'm also telling myself that. Because I still don't understand why I had to palliate my 6-year-old son, who had already shown such resilience in enduring cancer treatment after treatment for nearly 5 years.

Our second child, Edward (Ned), was born into our family on the 19th May 2012 – a healthy, thriving infant, albeit one who never slept. We struggled with excessive sleep deprivation in that first year, but after that, things started to improve. However in the latter half of his second year, his appetite started to wane, his sleep worsened again, and was becoming distressed easily particularly when walking. Just after his second birthday, at the end of a busy afternoon playing in a playground, he refused to stand or walk, and reverted to crawling around. I thought he'd had an unwitnessed fall at the playground perhaps, but then began the carousel of scans, and endless GP, orthopaedic and paediatrician appointments. Six weeks later, when I was 11 weeks pregnant with our third child, after a morning full of scans and blood tests, my husband and I were confronted with a teary paediatrician and a computer screen showing a blood panel indicative of leukaemia.

"My husband and I were confronted with a teary paediatrician and a computer screen showing a blood panel indicative of leukaemia."

I was, at the time, studying for my GP specialty medical exams, and leukaemia had barely featured on my radar of differential diagnoses. It floored us. We not only had to process our child having cancer, and convey that to our five-year-old Lucy, our extended family and the rest of our community, but we had to grieve the life we had planned and carved out in pursuit of what we thought God was calling us to – overseas missionary work. We were now tethered to a tertiary hospital in Tasmania, or at least Australia, for the next three and a half years at least. The biggest challenge, of course, was keeping our marriage intact and being grace-filled, patient, stable, loving parents to our two – nearly three – children over the coming years of intense treatment … as we soon found out …

The nearly five years of cancer treatment ahead, during which two more precious children were born to us, necessitated two bone marrow transplants and 18 months away from home – either interstate (Melbourne) or overseas (Seattle). I can't even begin to convey the profound depths of devastation with every bad result and leukaemia relapse, or the ecstatic highs where God, in His infinite mercy, provided just what we

needed (I did keep a blog: www.edwardisham.com). Our family lived a life of hyper-vigilance, uncertainty and separation – between hospital and our two-bedroom accommodation nearby. Our utterly depleted selves were sustained only by the prayers of many, the kindness of strangers, local friends, extended family and a new church we started attending; solely relying on God's strength to put each foot in front of the other, day after day, despite the seemingly-constant bad news and developing PTSD. So many small victories, followed by blows – relapse after relapse after relapse.

Ned's second bone marrow transplant was his last remaining chance. It was gruelling for us all, so you can imagine the triumph and celebrations upon its end and our return home at Christmas-time 2018, after 18 months away. We had fought valiantly, he had battled courageously, and we were victoriously given the prize of his life… or so we thought …

But in February 2019, on a return trip to Melbourne for numerous medical reviews, Ned's leukaemia was found to have returned aggressively – the fourth time. Our oncologist grimly said to me, "That's it. We have no more options. You need to take him home."

Palliating your own child is a truly surreal daily existence; made even more so in our case because I'm a doctor as well as a Mum – a vocation primarily focused on saving lives. It feels almost like an alternate reality – one in which the parameters of your old life have shifted dramatically. Where your prompting for your child's farewells needs to change from saying "see you later" to "goodbye". Where your utmost focus for your child is pain minimisation and comfort, no matter the cost, rather than considering the long-term consequences of certain medications. Where your daily self-expectations amount to simply responding to your children's frustrations and meltdowns calmly, and administering each of the numerous medications precisely via the correct route. Where the very sick child's irritability and lack of tolerance is granted

compassion rather than discipline. Where each day's usual firm routine and non-negotiable responsibilities are bent and moulded around each child's capacity. Where the little things, like brushing teeth, doing some physical activity, eating a variety of food, or even eating at all, no longer matter. Where getting each child to sleep the night in their own bed is no longer an aim. Where 'trust in God in each moment' is crystallised, for we know not which moment our son's life will end.

"Palliating your own child is a truly surreal daily existence; made even more so in our case because I'm a doctor as well as a Mum."

Everything's turned on its head when you're no longer trying to save your child, but merely keeping him comfortable, showing him as much love as possible until he returns to his Father. How do we prepare ourselves for this? How do we prepare our other children for this? Most importantly, how do we convey to our 6-year-old son that his life is going to end … and soon …

We had five weeks with Ned between us learning about his fourth relapse and his death. They should have been glorious, and in some ways they were – we had him alive with us, and oh how I long to have that time back. But we were shocked and grieving, not knowing what was around the corner, not knowing the timeline. With each short hospital visit or admission, we would wonder – is this real? Surely the doctors got it wrong? But just when we thought the chemo was holding his leukaemia at bay, he was admitted for pneumonia, and a bone marrow aspirate showed that it had in fact proliferated with a vengeance. And so … we took him home.

Being discharged home from hospital loses all its triumph and relief when one is bringing their child home to die. The anguish is so very painful, the sadness is so very profound.

Back home to a new, most unwelcome phase in a world of uncertainty. A phase whereby we bent to his every need and whim. Where we didn't need to cajole and implore him to "just eat a mouthful". Where we didn't need to stress about when to take him into hospital in case of deterioration. A phase where every moment was spent either pleading for God to have mercy and take it all away, or begging Him to carry me where my stamina faltered. It was a heart-wrenching and profoundly sorrow-filled few days and nights for us, reeling from the sudden realisation of our newly-contracted timeline with our darling son. And given his predominantly bed-bound state, his weakness, lethargy and fragility, we could no longer be ambitious in giving him special "lasts". Through God's strength alone we trudged, with His soul-filling peace replacing our prevailing fear and panic about what's ahead. He alone was our Rock amidst the sea of debilitating uncertainty.

But it turned out our son was better prepared for his death than any of us were anyway …

Not knowing the end was so nigh, Ned prayed this prayer the night before he died:

"Dear God.
Thank you for loving me.
Please help everyone have a good sleep.
I love you.
See you when I get to heaven.
Amen"

The rest of us have been left brokenhearted, to carry on since the 29th March 2019.

It's been two years since he left us. We have a new child in the family – two-month-old Beatrice Jean – her name labeling her as a 'bringer of joy', and reminding us that God is gracious. She doesn't in any way replace our Ned, and though we rejoice in her being, we continue to mourn with an all-consuming heartache, crying out to God in agony, raging and pleading with Him for answers.

We lament at everything that's gone against our wishes and the scars we bear. But while having faith doesn't make the pain hurt any less, it does allow us to see a God who's working out His plans to put an end to the evil and suffering in this world.

We know that Jesus understands suffering, sees our pain, and weeps with us, and it is by His grace alone that we continue on, eagerly anticipating the day when we'll be reunited once more with our Ned.

Blessing for the Brokenhearted

by Jan Richardson

'There is no remedy for love but to love more' — Henry David Thoreau

Let us agree for now
that we will not say the breaking
makes us stronger
or that it is better to have this pain
than to have done without this love.
Let us promise we will not
tell ourselves time will heal
the wound, when every day
our waking opens it anew.
Perhaps for now it can be enough
to ***simply marvel*** *at the mystery*
of how a heart so broken can go on beating,
as if it were made for precisely this —
as if it knows the only cure for love is more of it,
as if it sees the heart's sole remedy for breaking is to love still,
as if it trusts that its own persistent
pulse is the rhythm of a blessing we
cannot begin to fathom
but will ***save us nonetheless.***

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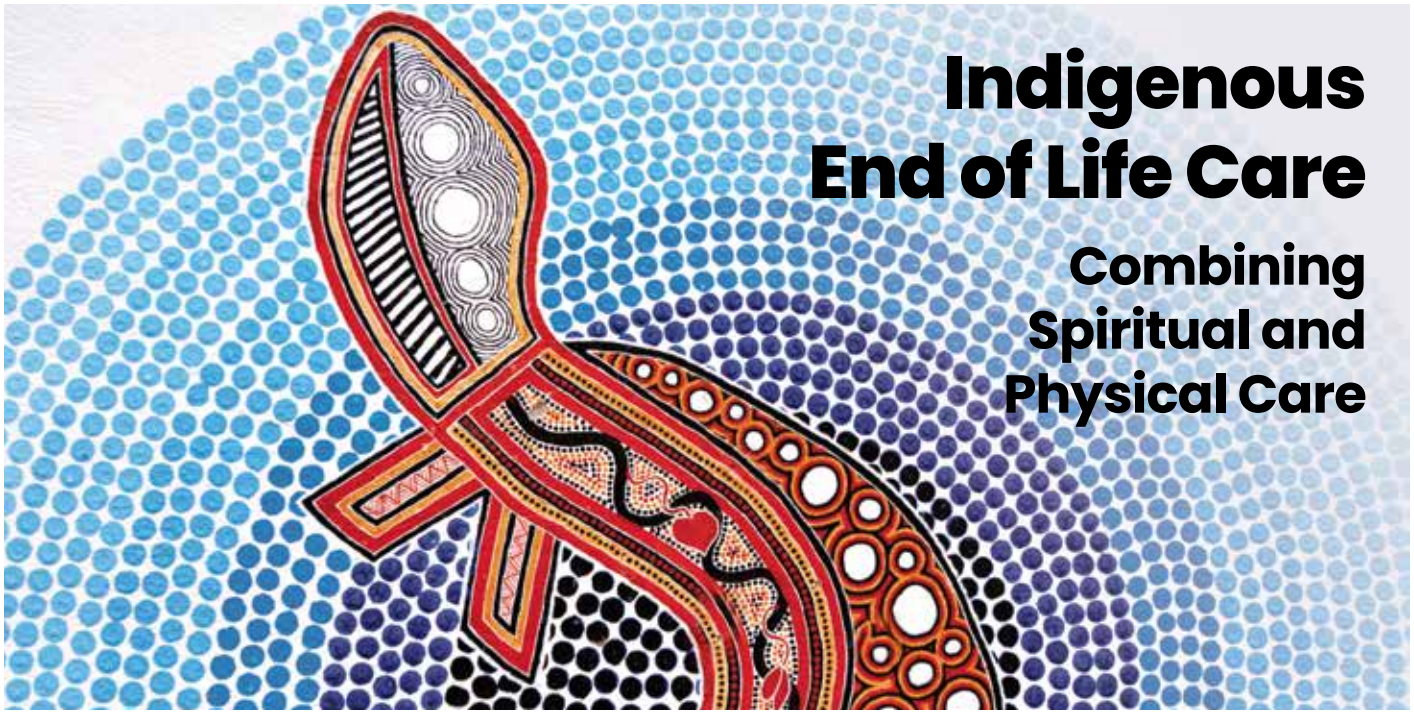
Wendy Harris RN
Wendy is currently working in Palliative Care as a Registered Nurse in Alice Springs, NT after moving from Newcastle, NSW. She enjoys being creative, going for walks in the beautiful scenery, spending time with friends and sharing God's word.



Indigenous End of Life Care

Combining Spiritual and Physical Care

Uncredited art. www.dreamstime.com

The Context

I arrived in Alice Springs as a newly graduated Registered Nurse from the east coast with the aim of developing skills as a missionary nurse.

I came with the attitude of "I will learn so much about *the* indigenous culture" by "being exposed to it". In a sense, this has happened. But what I have learnt is that there is no one indigenous culture to learn and master. Instead there are multiple layers to multiple cultures to explore, ask questions about, appreciate, decipher and watch, then know that I still can't "understand" it all.

Another thing I have learnt is that the diversity involved in indigenous health care, cultures and spiritual care is immense and impossible to write about with anything approaching uniformity. It is diverse at a national and local level in Central Australia due to the multiple indigenous people groups with different cultural and spiritual beliefs, different Christian denominations and historical contexts.

No Christian western healthcare practitioner in Alice Springs claims to have an in-depth understanding of indigenous culture, including me. In fact, the most Christ-like ones are humbly working alongside indigenous people and their health and spiritual leaders with genuine respect and love. These are the people I have looked up to when starting my nursing career in palliative care.

Where the Rubber Meets the Road

In all areas of palliative care, cultural and spiritual activity should be integral, as the aim of palliative care is to care for the whole person. In fact, to the local Arrente, Walpiri and Pitjara people, health and spiritual care are one and the same thing.

The area of palliative care that I have found the most challenging crossover between health and spiritual care

> ***"To the local Arrente, Walpiri and Pitjara people, health and spiritual care are one and the same thing."***

is terminal agitation (also known in literature as terminal restlessness or delirium). It is a form of delirium that can be very distressing for the person and their families - watching as the person experiences disorientation, confusion, paranoia, hallucinations. They can become physically and verbally aggressive as a result. This can be a sign that the person is hours or days away from dying.

The Situation

It was as a first year nurse that I first experienced a tough situation with a terminally agitated patient. The patient in question was a Christian indigenous man who was a leader in his community and was very respectful to others in his demeanour. During the course of the shift he developed delirium and was attempting to walk but did not have the strength. He was convinced we were trying to kill him, and at one point was trying to throw medical equipment at us. It took hours to resolve, and as we were the only two staff in the building we were also concerned for his safety and ours. We both wanted to give him appropriate medications to help him be more comfortable, however he vehemently refused and would not allow us near him.

This has not been an uncommon presentation for me through the years. At times patients have been hallucinating and talking to beings in the room that I cannot see, and no normal amount of medication or other therapies have been able to stop this.

Differentiating Spiritual and Medical Signs and Symptoms:

There is no doubt there were many medical reasons for this man developing terminal agitation and delirium. However, I have repeatedly fallen into the trap of just recognising the medical signs and symptoms the patient is displaying, and not recognising the way they can sometimes mask spiritual experiences. Symptoms of delirium in particular can be tricky to differentiate from severe spiritual interference.

the person already identifies with. In some of our local indigenous cultures, this can include *ngangkaries* or witch doctors whose intentions are to provide a form of spiritual care for patients using beliefs and practices that are not from God.

The question then is – how do I, as a Christian nurse, provide sound Biblical spiritual care when presented with indigenous patients who are experiencing spiritual and physical distress at the end of life? While I am by no means an expert or extremely experienced, God has been growing me in this area. Recognising that there is potential for there to be spiritual warfare waging over a patient who is close to dying is an essential aspect.

"How do I ... provide sound Biblical spiritual care when presented with indigenous patients who are experiencing spiritual and physical distress at the end of life?"

My Christian background is one of scepticism and lack of acknowledgement of different spiritual forces and Satan's use of them. This made it hard and surprising for me to be aware of the spiritual aspect involved in a patients' care at times. However, the Bible tells us that there are many ways that Satan works, including through cultures where spiritual beliefs are integral to everyday life and culture.

> *"See to it that no one takes you captive through hollow and deceptive philosophy, which depends on human tradition and the elemental spiritual forces of this world rather than on Christ."*
> (Colossians 2:8)

Combining Spiritual and Medical Care:

Palliative care is one of the few health care areas where the spiritual care of the person is actively encouraged. While this is a good thing from a Christian perspective, it does often involve only providing the form of spiritual care that such as medications – after all, God has given us all spiritual, emotional and physical tools to care for our patients.

Calling in the hospital chaplain, relevant priest or Christian leader to pray and read Scriptures with the patient and their family is also an effective form of spiritual care. We are blessed here to have chaplains, church ministers and lay people who are willing to provide quick and brilliant spiritual support for our patients and their families. I would strongly encourage any non-medical Christians to consider and pray about how God may use them in this form of spiritual care and warfare for any of your local palliative (indigenous or non-indigenous) people too.

> *"Be alert and of sober mind. Your enemy the devil prowls around like a roaring lion looking for someone to devour."*
> (1 Peter 5:8)

My first step now is to pray while actively caring. Only God can defeat any other spirits present at that time. This has worked many times since the first incident when nursing interventions alone have not. God has brought a spiritual peace into patient's rooms where there has previously only been a spiritual discord for the patient, their visitors and staff.

It is also important to keep actively caring for the patient and providing interventions

The Wrap Up:

The care of indigenous patients throughout Australia will be both similar and different depending on their culture, the culture of the people providing the care, the historical context and type of health care needed.

Providing good palliative care in Central Australia involves appreciating the pure beauty of God working through some of the Christian indigenous patients and seeing His grace and beauty from another perspective.

It has proven essential to be aware of the spiritual and physical health of the person, their cultural situation, and be ready and willing to submit to God's strength in engaging with different spiritual forces.

"My first step now is to pray while actively caring."

> *"Finally, be strong in the Lord and in his mighty power. Put on the full armor of God, so that you can take your stand against the devil's schemes. For our struggle is not against flesh and blood, but against the rulers, against the authorities, against the powers of this dark world and against the spiritual forces of evil in the heavenly realms."*
> (Ephesians 6:10-12)

Book Review

Rich in Years: Finding Peace and Purpose in a Long Life[1] – by Johann Christoph Arnold

This book is a window into ageing and how much God loves and accepts us as we grow older. However, society (Christians included) often looks at old age with little regard, and certainly not as a blessing.

The poetry, songs and Scriptures cited in *Rich in Years* draw you into a world filled with both blessings and responsibilities. Knowledge of God can lead us into an era of new adventure with grace and a good laugh. Nearing death does not mean fighting an enemy. Christ has preceded us, He is victorious. So if we accept God's will for us to live a long life, we can consider it a gift.

The author writes that we elderly have a responsibility to accept this gift as a way of encouraging others to find the peace of Christ. This replaces focussing on the loss of activities and pleasures in which we no longer partake as our faculties and physical strength fail. In old age we have more time to work for the Kingdom of God here on earth, living Jesus' words, *"Love the Lord your God with all your heart and with all your soul and with all your mind,"* and putting into action Jesus final commandment to us, *"Love your neighbour as yourself"* (Matt.22:37–39).

Rich in Years challenges the concept that ageing isn't funny. Can it be funny? In the words of the author's friend, Pete Seeger, in his song *Get Up and Go*[2], "Yes, it can."

However, it's not a laughing matter when one's mobility is lost. As Bette Davis said, "Old age ain't no place for sissies" (quoted in *Rich in Years* as a bumper sticker![3]). There certainly are trials, death of loved ones, illness and perhaps the onset of some form of dementia. While it's difficult to face our own mortality, the insights in this book address our fears and help us live with some of our regrets or failures, and the desire to have perhaps done things differently - perhaps loved others more. There is no time for bitterness or dwelling on how we've messed up our lives. By allowing God's grace to carry our burdens, we can make the most of our remaining time and spend it giving thanks for what we have experienced.

There are many stories of people from very diverse backgrounds, stories of ageing, accepting change, overcoming loneliness, finding purpose, keeping the faith, as well as moving forward and finding peace. Saying goodbye and moving on are indicative of starting something new, even in old age. Many of the Scriptures quoted confirm that eternity awaits those who believe in Jesus Christ. Several chapters speak of the promise of everlasting life which can be lived now with joy and peace, fellowship and abundance: "Deep down we all long for that."[4]

The content of *Rich in Years* is easily sourced by virtue of the exhaustive index of names of people referenced; from the author's own family, to poets and Popes, community workers and cardinals, singers and writers. Martin Luther King Jr and Mother Teresa feature, amongst others, as illustrious yet humble people met by the author.

Georgina Hoddle RN

Georgina is a registered nurse (RN) with experience in orthopaedics and trauma, ageing and disability. She is currently retiring from her part-time role as NSW Health Authorised Nurse Immuniser and now only works casually in Aged Care. Georgina graduated from Macquarie University with a Master in Applied Linguistics (TESOL; 2011) and is using her language skills to write book reviews and articles of current interest. Georgina is currently Vice President of Nurses Christian Fellowship and trains Christian healthcare workers to be witnesses to Jesus Christ through the Saline Process.

The Author

Johann Christoph Arnold has won many awards for his books of which more than a million copies have been sold, printed in more than 20 languages. Arnold is senior pastor of Bruderhof, a movement of Christian Communities. He started the American public high school program called Breaking the Cycle[5] which aims to promote reconciliation through forgiveness. For more on the author, you are encouraged to read *Rich in Years*.

Reviewer's note: The acclaim this book has received, from many also known to our Australian Christian community such as Megan Best and Tim Costello, inspired me to read it cover to cover one wet weekend. The power had failed and the only light available came from my computer screen; soon these words appeared :*"Come to me, all you who are weary and burdened, and I will give you rest"*(Matt. 11:28). These words provided the light required to move on from a position of stasis in the early days of my retirement. *Rich in Years*, indeed.

References:

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2. "Old Age is Golden" https://www.youtube.com/watch?v=OdNQt4a6f7g
3. "Ageing is not for sissies" p.17
4. p.148.
5. www.breakingthecycle.com

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Having completed a Masters of Ministry at Morling College I found the tools to apply and teach a Christian perspective for both bedside and colleague spiritual care.

I realised that God has not 'sent' me to work but in fact delights in co-labouring with me in the privileged path that each nursing shift provides me.

I am learning (and teaching) how to infuse my Christian faith into my workplace and can honestly say I am loving the opportunities this has brought to my journey. For me taking my faith to work is now second nature and I am so grateful for how gentle yet powerful is His presence through me."

- Gabrielle Macaulay

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